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THCIC ID: 000100 / Austin State Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Due to system limitations, note, that this is just an estimate and relates to identified source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also includes emergency admissions.

Admission Source = Because of system constraints, all admission sources on the encounter recrods, are reported as court/law enforcement. The data reported also includes voluntary admissions. The local Mental Health Authority refers the majority of admissions.

Patient Discharge Status = All patients, when discharged, are referred to the local Mental Health Authority.

Standard Source of Payment = Because of system constraints, all payment sources on the encounter records are, reported as charity. The sources of payments, by percent, are:

Standard Source of Payment	Total Percentage (%)
Self-Pay	2.52%
Worker's Comp	n/a
Medicare	10.48%
Other Federal Program	8.06%
Commercial	3.71%
Blue Cross	n/a
Champus	0.18%
Other	n/a
Missing/Invalid	n/a

Non-Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a
Commercial	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.02%
Commercial HMO	n/a
Charity	75%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be danger to self or others and the severity of illness is determined by an acuity assessment performed by the hospital. The Severity Index on the encounter record for each patient is assigned based on the patient's APR-DRG (All Patient Refined-Diagnosis Related Groups, Which does not reflect the severity of mental illness due to reporting methodology.

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THCIC ID: 000101 / Big Spring State Hospital

QUARTER: 4
YEAR: 1999

Certified with comments

Due to system limitations, note, that this is just an estimate and relates to identified source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also inlcudes emergency admissions.

Admission Source = Because of system constraints, all admission sources on the encounter records are reported as court/law enforcement. The data reported also includes voluntary admissions. The local Mental Health Authority refers the majority of admissions.

Patient Discharge Status = All patients, when discharged, are referred to the local Mental Health Authority.

Standard Source of Payment = Because of system constraints, all payment sources on the encounter records are reported as charity. The sources of payments, by percent are:

Standard Source of Payment	Total Percetange (%)
Self-Pay	2%
Worker's Comp	n/a
Medicare	4.91%
Medicaid	9.49%
Other Federal Program	n/a
Commercial	1.49%
Blue Cross	n/a
Champus	1.06%
Other	n/a
Missing/Invalid	n/a

Non-Standard Source of Payment	Total Percentage (%)
State Local Government	n/a
Commercial PPO	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.0%
Commercial HMO	n/a
Charity	81%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be a danger to self or others and the severity of illness is determined by an acuity assessment performed by the hospital. The Severity Index on the encounter record for each patient is assigned based on the patient's APR-DRG (All Patient Refined-Diagnosis Related Groups, which does not reflect the severity of mental illness due to reporting methodology.

Deleted Discharge Data = There was a system mapping problem due to interim claims file which cause some of the discharge data to be

deleted. The true discharge count for the 4th quarter 1999 is 397.

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THCIC ID: 000102 / University of Texas Medical Branch Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

There are some discrepancies in the Certification Summary Reports related to our reporting of Admission Source, Patient Age Breakdown, and Standard Source of Payment. We are not prepared to correct these errors immediately, but will be working internally and with THCIC to correct during this next quarter.

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THCIC ID: 000104 / Rio Grande State Center
QUARTER: 4
YEAR: 1999

Certified with comments

Due to system limitations, note, that is just an estimate and relates to identified source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also includes emergency admissions.

Admission Source = Because of system constraints, all admission source on the encounter records are reported as court/law enforcement. The data reported also inludes voluntary admissions. The local Mental Health Authority refers the majority of admissions.

Patient Discharge Status = All patients, when discharged, are referred to the local Mental Health Authority.

Standard Source of Payment = Because of system constraints, all payment sources on the encounter records are, reported as charity. The sources of payments, by percent, are:

Standard Source of Payment:	Total Percentage (%)
Self-Pay	0.55%
Worker's Comp	n/a
Medicare	5.92%
Medicaid	7.32%
Other Federal Program	n/a
Commercial	0.87%
Blue Cross	n/a
Champus	0.32%
Other	n/a
Missing/Invalid	n/a

Non-Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a
Commercial PPO	n/a
Medicare Managed Care	n/a

Medicaid Managed Care	0.0%
Commercial HMO	n/a
Charity	85%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be a danger to self or others and the severity of illness is determined by an acuity assessment performed by the hospital. The Severity Index on the encounter record for each patient is assigned based on the patient's APR-DRG (All Patient Refined-Diagnosis Related Groups), which does not reflect the severity of mental illness due to reporting methodology

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THCIC ID: 000105 / University of Texas M.D. Anderson Cancer Center
QUARTER: 4
YEAR: 1999

Certified with comments

THCIC Intro

The University of Texas M.D. Anderson Cancer Center is one of the nation's first three comprehensive Cancer Centers designated by the National Cancer Act and remains one of only 36 such centers today that meet the rigorous criteria for NCI designation. Dedicated solely cancer patient care, research, education and prevention, M.DAnderson also was named the best cancer center in the United States by the U.S. News & World Report's "America's Best Hospitals" survey in July 2000. As such, it was the only hospital in Texas to be ranked number one in any of the 17 medical specialties surveyed.

Because M.D. Anderson consults with, diagnoses and treats only patients with cancer, it is important in the review of these data that key concepts about cancer and patient population are understood. Such information is vital to the accurate interpretation and comparison of data.

Cancer is not just one disease. Rather, it is a collection of 100 or more diseases that share a similar process. Some forms of the disease are serious and life threatening. A few pose little threat to the patient, while the consequences of most cancers is in between.

No two cancers respond to therapy in exactly the same way. For example, in order to effectively treat a breast cancer, it must be staged according to the size and spread of the tumor. Patients diagnosed with Stage I and Stage IV breast cancer may both receive radiation therapy as treatment, but two distinctive courses of treatment and doses are administered, dependent on the stage of the disease. Even two Stage I breast cancers can respond differently to the treatment.

M.D. Anderson treats only patients with cancer and their related diseases. As such, the population is comparable to a total patient population of a community hospital, which may deliver babies, perform general surgery, operate a trauma center and treat only a small number of cancer patients.

Congress has recognized M.D. Anderson's unique role in providing state of the art cancer care by exempting it from the DRG-based inpatient prospective payment system. Nine other freestanding NCI designated cancer centers are also exempt.

Because M.D. Anderson is a leading center for cancer research, several hundred patients may be placed on clinical trials every year, rather than -- or in addition to -- standard therapies. Highly regulated and monitored, clinical trials serve to improve conventional therapies and provide new options for patients.

Patients often come to M.D. Anderson for consultation only. With M.D. Anderson physicians consulting with their hometown oncologists, patients often choose to get treatment at home rather than in Houston.

More than half of M.D. Anderson's patients has received some form of cancer treatment before coming to the institution for subsequent advice and treatment. This proportion is far higher than in general hospitals, making it difficult to compare M.D. Anderson to community facilities.

As a public institution, M.D. Anderson welcomes inquiries from the general public, advocacy organizations, the news media and others regarding this data. Inquiries may be directed to Julie Penne in the Office of Communications at 713/792-0655.

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THCIC ID: 000106 / Kerrville State Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Due to system limitations, note, that this is just an estimate and relates to identified source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also includes emergency admissions.

Admission Source = Because of system constraints, all admission sources on the encounter records are reported as court/law enforcement. The data reported also includes voluntary admissions. The local Mental Health Authority refers the majority of admissions.

Patient Discharge Status = All patients, when discharged, are referred to the local Mental Health Authority.

Standard Source of Payment = Because of system constraints, all payment sources on the encounter records are, reported as charity. The sources of payment, by percent, are:

Standard Source of Payment:	Total Percentage (%)
Self-Pay	4.90%
Worker's Comp	n/a
Medicare	2.92%
Medicaid	12.21%
Other Federal Program	n/a
Commercial	2.95%
Blue Cross	n/a
Champus	0.00%
Other	n/a

Missing/Invalid	n/a

Non-Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a
Commercial PPO	n/a
Medicaid Managed Care	n/a
Medicare Managed Care	0.00%
Commercial HMO	n/a
Charity	77%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be a danger to self or others and the severity of illness is determined by an acuity assessment performed by the hosptial. The Severity Index on the encounter record for each patient is assigned based on the patient's APR-DRG (All Patient Refined-Diagnosis Related Groups), which does not reflect the severity of mental illness due to reporting methodology.

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THCIC ID: 000107 / Rusk State Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Due to system limitations, note, that this is just an estimate and relates to identified source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also includes emergency admissions.

Admission Source = Because of system constraints, all admission source on the encounter records are reported as court/law enforcement. The data reported also includes voluntary admissions. The local Mental Health Authority refers the majority of admissions.

Patient Discharge Status = All patients, when discharged, are referred to the local Mental Health Authority.

Standard Source of Payment = Because of system constraints, all payments sources on the encounter records are, reported as charity. The sources of payments, by percent, are:

Standard Source of Payment	Total Percentage (%)
Self-Pay	1.65%
Worker's Comp	n/a
Medicare	9.15%
Medicaid	5.18%
Other Federal Government	n/a
Commercial	1.99%
Blue Cross	n/a
Champus	0.0%
Other	n/a
Missing/Invalid	n/a

Non-Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a
Commercial PPO	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.0%
Commercial HMO	n/a
Charity	82%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be a danger to self or others and the severity of illness is determined by an acuity assessment performed by the hospital. The Severity Index on the encounter record for each patient is assigned based on the patient's APR-DRG (All Patient Refined-Diagnosis Related Group), which does not reflect the severity of mental illness due to reporting methodology.

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THCIC ID: 000108 / Texas Center for Infectious Disease
QUARTER: 4
YEAR: 1999

Certified with comments

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THCIC ID: 000110 / San Antonio State Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Due to system limitations, note, that this is just an estimate and relates to identifed source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also includes emergency admissions.

Admission Source = Because of system constraints, all admission sources on the encounter records are reported as court/law enforcement. The data reported also includes voluntary admissions. The local Mental Health Authority refers the majority of admissions.

Patient Discharge Status = All patients, when discharged, are referred to the local Mental Health Authority.

Standard Source of Payment = Because of system constraints, all payment sources on the encounter records are, reported as charity. The sources of payment, by percent, are:

Standard Source of Payment	Total Percentage (%)
Self-Pay	0.87%
Worker's Comp	n/a
Medicare	8.65%

Medicaid	15.43%
Other Federal Program	n/a
Commercial	1.46%
Blue Cross	n/a
Champus	0.44%
Other	n/a
Missing/Invalid	n/a

Non-Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a
Commercial PPO	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.12%
Commercial HMO	n/a
Charity	73%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be a danger to self or others and the severity of illness is determined by an acuity assessment performed by the hospital. The Severity Index on the encounter record for each patient is assigned based on the patient's APR-DRG (All Patient Refined-Diagnosis Related Group), which does not reflect the severity of mental illness due to reporting methodology.

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THCIC ID: 000111 / Terrell State Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Due to system limitations, note, that this is just an estimate and relates to identified source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also includes emergency admissions.

Admission Source = Because of system constraints, all admission sources on the encounter records are reported as court/law enforcement. The data reported also includes voluntary admissions. The local Mental Health Authority refers the majority of admissions.

Patient Discharge Status = All patients, when discharged, are referred to the local Mental Health Authority.

Standard Source of Payment = Because of system constraints, all payment sources on the encounter records are, reported as charity. The sources of payment, by percent, are:

Standard Source of Payment	Total Percentage (%)
Self-Pay	1.29%
Worker's Comp	n/a
Medicare	11.18%
Medicaid	3.10%

Other Federal Program	n/a
Commercial	0.36%
Blue Cross	n/a
Champus	0.0%
Other	n/a
Missing/Invalid	n/a

Non-Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a
Commercial PPO	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.0%
Commercial HMO	n/a
Charity	84%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be a danger to self or others and the severity of illness is determined by an acuity assessment performed by the hospital. The Severity Index on the encounter record for each patient is assigned based on the patient's APR-DRG (All Patient Refined-Diagnosis Related Groups), which does not reflect the severity of mental illness due to reporting methodology.

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THCIC ID: 000113 / N TX State Hospital Vernon
QUARTER: 4
YEAR: 1999

Certified with comments

Due to system limitations, note that this is just an estimate and relates to identified source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also includes emergency admissions.

Patient Discharge Status = All patients, when discharged, are either sent to a civil state hospital (as not manifestly dangerous but still incompente) or to jail (as competent to stand trial or for a revision of their commitment as incompetent to stand trial.

Standard Source of Payment = Becauser of system constraints, all payment sources on the encounter records are, reported as charity. The sources of payments, by percent, are:

Standard Source of Payment:	Total Percentage (%)
Self-Pay	1.11%
Workers's Comp	n/a
Medicare	0.30%
Medicaid	15.23%
Other Federal Program	n/a
Commercial	2.16%
Blue Cross	n/a
Champus	0.13%

Other	n/a
Missing/Invalid	n/a

Non-Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a
Commercial PPO	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.05%
Commercial HMO	n/a
Charity	81%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be a danger to self or other and the severity of illness is determined by an acuity assessment performed by the hospital. The Severity Index on the encounter record for each patient is assigned based on the patient's APR-DRG (All Patiend Refined-Diagnosis Related Groups), which does not reflect the severity of mental illness due to reporting methodology.

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THCIC ID: 000114 / N TX State Hospital Wichita Falls
QUARTER: 4
YEAR: 1999

Certified with comments

Due to system limitations, note, that this is just an estimate and relates to identified source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also includes emergency admissions.

Admission Source = Because of system constraints, all admission sources on the encounter records are reported as court/law enforcement. The data reported also includes voluntary admissions. The local Mental Health Authority refers the majority of admissions.

Patient Discharge Status = All patients, when discharged, are referred to the local Mental Health Authority.

Standard Source of Payment = Because of system constraints, all payment sources of the encounter records are, reported as charity. The sources of payments, by percent, are:

Standard Source of Payment:	Total Percentage (%)
Self-Pay	1.85%
Worker's Comp	n/a
Medicare	5.68%
Medicaid	8.22%
Other Federal Program	n/a
Commercial	2.73%
Blue Cross	n/a
Champus	0.47%
Other	n/a

MIssing/Invalid n/a

Non-Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a
Commercial PPO	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.02%
Commercial HMO	n/a
Charity	81%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be a danger to self or others and the severity of illness is determined by an acuity assessment performed by the hospital. The Severity Index on the encounter records for each patient is assigned based on the patient's APR-DRG (All Patient Refined-Diagnosis Related Groups), which does not reflect the severity of mental illness due to reporting methodology.

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THCIC ID: 000115 / Harris County Psychiatric
QUARTER: 4
YEAR: 1999

Certified with comments

Fourth Quarter Certification Attachment

1. Patient Discharge Status - Due to a computer field default value of "discharge to home or self care," the majority of discharges for the period were automatically coded to this value. Beginning in August 2000, the computer default was eliminated and data from that time forward will reflect a correct value.

2. Admission Source - The code for Correctional Agency (11) was inadvertently added to the code for physician's (1) for the admission source field. This caused 11 patients to be recorded with the wrong admission source. We have corrected this problem for future data.

3. Patient Age - Two patients records were changed from 1-17 age group to the 18-44 age group as a result of patient record corrections being performed after the original file was submitted.

4. Patient Race - One patient record was changed from a designation of American Indian/Eskimo to Other as a result of patient record corrections being performed after the original file was submitted.

5. Patient Ethnicity - One patient record was changed from Non-Hispanic origin to Hispanic origin as a result of patient record corrections being performed after the original file was submitted.

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THCIC ID: 002001 / St Joseph Regional Health Center
QUARTER: 4
YEAR: 1999

Certified with comments

Data Source - The data included in this file is administrative, not clinical

research data. Administrative data may not accurately represent the clinical details of a patient visit. This data should be cautiously used to evaluate health care quality and compare outcomes.

Charity Care - Data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for St. Joseph Regional Health Center charity care, based on established rates during the calendar year of 1999 was $9,086,476.

Patient Mix - All statistics for St. Joseph Regional Health Center include patients from our Skilled Nursing, Rehabilitation, and Acute Care populations. Our Skilled Nursing and Rehabilitation units are long-term care units. Because of this Mortality and Length of Stay may be skewed. This will prohibit any meaningful comparisons between St. Joseph Regional Health Center and any "acute care only" facilities.

Physicians - Mortality's reported may be related to physicians other than the attending
Physician. The attending physician is charged with the procedures requested or performed by the consulting or specialist physicians.

Diagnosis and Procedures - Data submitted to the state may be incomplete for some patients due to the limitation on the number of diagnosis and procedures codes allowed. The data is limited to nine diagnoses codes and six procedure codes per patient visit.

Cost and Charges - The state requires that we submit revenue information including charges. It is important to note that charges do not reflect actual reimbursement received, nor do they reflect the actual cost of providing the services. Typically actual payments received are much less than the charges due to managed care-negotiated discounts, denial of payment by insurance companies, contractual allowances, as well as charity and un-collectable accounts. The relationship between cost of care, charges, and the revenue a facility receives is extremely complex. Comparing costs of care from one hospital to the next may result in unreliable results.

Severity Adjustment - THCIC is using the 3M APR-DRG grouper to assign the APR-DRG (All-Patient Refined Diagnoses Related Grouping) severity and risk of mortality scores. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status. This grouper can only use the limited number of procedure and diagnosis codes available in the data file (nine diagnosis and six procedure codes). If all the patient's diagnosis codes were available the APR-DRG assignment may possibly differ from the APR-DRG assigned by THCIC. The severity grouping assignment performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper. Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation
of the data.

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YEAR: 1999

Certified with comments

Matagorda General Hospital had 112 newborn discharges for 4th Qtr 1999. THCIC only processed 99 due to 13 newborn discharges that were coded incorrectly by MGH. These 13 discharges were coded as urgent or elective admissions instead of newborn under admit type.

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THCIC ID: 015000 / CHRISTUS St Joseph Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

St. Joseph certified the data but could not account for 28 patients due to processing the patients after the data was submitted.

During this time period St. Joseph Hospital provided charity care

for 392 patients with the total charges over 2 million dollars. The system didn't identify these patients.

St. Joseph data didn't correspond to the newborn admission, according to our data we had 63 premature infants and 262 sick infants.

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THCIC ID: 019000 / Valley Regional Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

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THCIC ID: 027000 / Baylor Medical Center at Garland
QUARTER: 4
YEAR: 1999

Certified with comments

Data Content
This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate; this was a unique, untried use of this data as far as hospitals are concerned.

Submission Timing
Baylor estimates that our data volumes for the calendar year time period submitted may include 96% to 100% of all cases for that time period. The state requires us to submit a snapshot of billed claims, extracted

from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in.

Diagnosis and Procedures
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Normal Newborns
The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Baylor's normal hospital registration process defaults "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

Race/Ethnicity
During the hospital's registration process, the registration clerk does

not routinely inquire as to a patient's race and/or ethnicity. The race data element is subjectively captured and the ethnicity data element is derived from the race designation. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 73.21% of encounters originally categorized across all values have a different value as of today. Upon review an additional data issue was uncovered. All managed care encounters were categorized as "Commercial PPO" instead of separating the encounters into "HMO" versus "PPO".

Additionally, those payers identified contractually as both "HMO and PPO" are categorized as "Commercial PPO". Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

Certification Process
Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. During the current certification phase, Baylor did not have an efficient mechanism to edit and correct the data. In addition, due to the volume at Baylor, it is not feasible to perform encounter level audits.

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THCIC ID: 028000 / Vencor Hospital - Dallas
QUARTER: 4
YEAR: 1999

Certified with comments

We are a Long Term Acute Care Hospital so we have a much greater average length of stay. In addition, our hospital averages a higher CMI (acuity index) which does result in a higher mortality rate than short term acute care hospitals.

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THCIC ID: 028001 / Vencor Hospital - Dallas East

QUARTER: 4
YEAR: 1999

Certified with comments

We are a Long Term Acute Care Hospital so we have a much greater average length of stay. In addition, our hospital averages a higher CMI (acuity index) which does result in a higher mortality rate than short term acute care hospitals.

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THCIC ID: 029000 / Good Shepherd Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments* corrections requested

One physician has stated "The amount of effort that will be required to organize this data on thousands of doctors in Texas would exceed what anyone would benefit from."

One claim was not included in our 4th Quarter Certification which was UBF00751_008 submitted on 10/11/2000 for Dec 1999 for a total of 1 claim for a total of $21,604.65 which understated the total charges for the C02 report.

We have identified some potential problems in the following areas: newborn admissions, ethnicity, discharge disposition, and race. We will have a batch of corrections to follow soon.

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THCIC ID: 035000 / St Davids Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

1.) The data is administrative/claims data, not clinical research data. There may be inherent limitations to using it to compare outcomes.

2.) The public data will only contain a subset of the diagnoses and procedure codes, thus limiting the ability to access all of the diagnoses and procedures relative to each patient.

3.) The relationship between cost of care, charges and the revenue that a facility receives is extemely complex. Inferences to comparing costs of care from one hospital to the next may result in unreliable results.

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THCIC ID: 040000 / Providence Health Center
QUARTER: 4
YEAR: 1999

Certified with comments

A. Due to a data mapping error, 9 records from the DePaul Center (THCIC #763000) were inadvertently submitted under Providence Health Center's THCIC Number (THCIC #040000). The accounts had the following HCFA DRGs:

HCFA DRG NO - Quantity

HCFA DRG 426 - 1
HCFA DRG 427 - 1
HCFA DRG 430 - 5
HCFA DRG 431 - 2

B. Of total deaths, 11 (14%) were hospice patients.

==========

THCIC ID: 041000 / Madison St Joseph Health Center
QUARTER: 4
YEAR: 1999

Certified with comments

Data Source - The data included in this file is administrative, not clinical research data. Administrative data may not accurately represent the clinical details of a patient visit. This data should be cautiously used to evaluate health care quality and compare outcomes.

Charity Care - Data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for Madison St. Joseph Health Center charity care, based on established rates during the calendar year of 1999 was $174,713.

Patient Mix - All statistics for Madison St. Joseph Health Center include patients from our Skilled Nursing, and Acute Care populations. Our Skilled Nursing unit is a long-term care unit. Because of this Mortality and Length of Stay may be skewed. This will prohibit any meaningful comparisons between Madison St. Joseph Health Center and any "acute care only" facilities.

Physicians - Mortality's reported may be related to physicians other than the attending
Physician. The attending physician is charged with the procedures requested or performed by the consulting or specialist physicians.

Diagnosis and Procedures - Data submitted to the state may be incomplete for some patients due to the limitation on the number of diagnosis and procedures codes allowed. The data is limited to nine diagnoses codes and six procedure codes per patient visit.

Cost and Charges - The state requires that we submit revenue information including charges. It is important to note that charges do not reflect actual reimbursement received, nor do they reflect the actual cost of providing the services. Typically actual payments received are much less than the charges due to managed care-negotiated discounts, denial of payment by insurance companies, contractual allowances, as well as charity and un-collectable accounts. The relationship between cost of care, charges, and the revenue a facility receives is extremely complex. Comparing costs of care from one hospital to the next may result in unreliable results.

Severity Adjustment - THCIC is using the 3M APR-DRG grouper to assign the APR-DRG (All-Patient Refined Diagnoses Related Grouping) severity and risk of mortality scores. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge

status. This grouper can only use the limited number of procedure and diagnosis codes available in the data file (nine diagnosis and six procedure codes). If all the patient's diagnosis codes were available the APR-DRG assignment may possibly differ from the APR-DRG assigned by THCIC. The severity grouping assignment performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper. Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation
of the data.

==========

THCIC ID: 042000 / Trinity Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

DATA Content
This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called a UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate; this was a unique, untried use of this data as far as hospitals are concerned.

Submission Timing
The hospital estimates that our data volumes for the calendar year time period submitted may include 96% to 100% of all cases for that time period. The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in.

Diagnosis and Procedures
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of the patient's hospitalization, sometimes significantly.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One

limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedures codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes in an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Specialty Services
The data submitted does not have any specific data field to capture unit of service or expand in the specialty service (such as rehab) provided to a patient. Services used by patients in rehab may be very different from those used in other specialties. The data is limited in its ability to categorize patient type.

Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay as long as or longer than 999 days, therefore, it is not anticipated that this limitation will affect this data. The hospital does have an inpatient rehabilitation unit whose patients stay an average of 12 days. This may skew the data when combined with other acute care patient stays.

Normal Newborns
The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. The hospital's normal hospital registration process defaults "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

Race/Ethnicity
During the hospital's registration process, the registration clerk does routinely complete patient's race and/or ethnicity field. The race data element is sometimes subjectively captured and the ethnicity data element is derived from the race designation. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Cost/Revenue
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to negotiated discounts with 3rd party payors. Charges also do not reflect the actual costs to deliver the care that each patient needs.

Certification Process
Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. During the current certification phase, the hospital did not have an efficient mechanism to edit and correct the data. In addition, it is not feasible to perform encounter level audits at this time.

==========

THCIC ID: 047000 / Huguley Health Systems
QUARTER: 4
YEAR: 1999

Certified with comments

Data Content
The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of January 31, 2001. Under the requirements we are unable to alter our comments after today. If any errors are discovered in our data after this point we will be unable to communicate these due to THCIC. This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

Submission Timing
The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in.

Diagnosis and Procedures
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected. Also, the state's reporting system does not allow for severity adjustment at this time.

There is no mechanism provided in the reporting process to factor in DNR (Do Not Resuscitate) patients. Any mortalities occurring to a DNR patient are not recognized separately; therefore mortality ratios may be accurate for reporting standards but overstated.

Physicians Clarification
When patients are admitted through the emergency department and the ER doctor receives an order from a physician on call to admit a patient, the physician issuing the order on occasion has remained the attending physician. This occurred when there was no order transferring the care of the patient from the on call physician to the actual attending physician. This policy is being reviewed.

Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

The state's guidelines do not allow for differentiation for acute and long-term care patients in statistics. Skilled nursing patients routinely have longer length of stay than acute care patients and therefore should not be included together in statistics. The healthcare industry generally differentiates these two classifications.

Race/Ethnicity
During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race data element is subjectively captured and the ethnicity data element is derived from the race designation. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population serviced by the hospital.

Certification Process
Due to the infancy of the state reporting process and the state's computer

system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. During the current certification phase, we did not have an efficient mechanism to edit and correct the data. In addition, due to patient volume and time constraints, it is not feasible to perform encounter level audits.

==========

THCIC ID: 071000 / College Station Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

1. The data is administrative/claims data, not clinical research data. There may be inherent limitations to using it to compare outcomes.

2. The public data will only contain a subset of the diagnoses and procedure codes, thus limiting the ability to access all of the diagnoses and procedures relative to each patient.

3. The relationship between cost of care, charges and the revenue that a facility receives is extremely complex. Inferences to comparing costs of care from one hospital to the next may result in unreliable results.

4. The severity grouping assignment performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper. Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation
of the data.

5. There is tremendous uncertainty about how robust physician linkages will be done across hospitals.

6. Race/Ethnicity classification is not done systematically within or between facilities. Caution should be used when analyzing this data within one facility and between facilities.

7. Mortality's reported may be related to physicians other than the attending physician.

8. Mortality and length of stay may be skewed because of the Skilled Nursing Facility.

==========

THCIC ID: 072000 / Memorial Medical Center San Augustine
QUARTER: 4th
YEAR: 1999

Certified with comments

17% of the physicians responded to THCIC data. They felt, to the best of their knowledge, the information was accurate.
We understand their may be discrepencies due to software conflicts. This will be eliminated in the future due to changes in software vendor and system.

==========

THCIC ID: 076000 / Tomball Regional Hospital
QUARTER: 4

YEAR: 1999

Elect not to certify

I elect not to certify the information because:

The information reported in the report is misleading to the genreal public.

The attending physician is charged with the procedures requested or performed by the consulting or specialist physicians due to the acuity and needs of the patient:

Physician has extremely high mortality rate because he only treats end stage cancer patients in Hospice care.

No allowance is made for procedures by specialists, mortality, etc.

==========

THCIC ID: 081000 / Southeast Baptist Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Comments:
This is administrative data that has been collected on a national standard form called a UB-92, for the purpose of billing third party organizations for reimbursement.
This billing data was not collected for clinical purposes from which one could easily
make judgements about patient care. Acknowledging the constraints and limitations of
the THCIC process, to the best of our knowledge the THCIC data are reasonable representations of the administrative data except for two items that merit specific
comment.

Standard/Non-Standard Sources of Payment
This data is not contained within the national standard UB-92 record used for billing.
Therefore, additional programming was required to capture and provide the specified
categories of payment. The effectiveness of this programming will be monitored and
refined on a go-forward basis to achieve an appropriate degree of accuracy in the data.

Age Classification of Patients
The data reflect several occurrences of highly unusual reported ages of patients in
the Normal Newborn, Vaginal Delivery and Neonate categories and we cannot attest to
the accuracy of this suspect data. We are researching these variances in an effort
to determine the cause for the aberrations in reported ages.

==========

THCIC ID: 095000 / CHRISTUS St Josephs Health System
QUARTER: 4

YEAR: 1999

Certified with comments

One encounter was taken by THCIC's version 15 grouper and placed in MDC 14 and reported on the certification summary report as Newborn and OB. This encounter was not a birth but was an adult patient with an obstetrical related case. We felt this comment was necessary, as our facility does not have an OB department per se.

==========

THCIC ID: 106000 / Northeast Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

The number of encounters in the race category are in error. Corrections are as follow:
American Indian/Eskimo/Aleut: 5
Asian or Pacific Islander: 0
Black: 15
White: 331
Other: 2

==========

THCIC ID: 108000 / Cleveland Regional Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

Our November 1999 encounter data does not appear on this submission. We are aware of this and are taking measures to ensure that this error is prevented on future submissions.

==========

THCIC ID: 109000 / Covenant Medical Center Lakeside
QUARTER: 4
YEAR: 1999

Certified with comments

Data does not accurately reflect the hospital's newborn population.
Total Births = 194
Live = 169
Premature = 25

Data does not accurately reflect the number of charity cases for the time period.
This is due to internal processing for determination of the source of payment.
4% of total discharges were charity for 4 Quarter 1999.

==========

THCIC ID: 114000 / Baptist Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

Comments:
This is administrative data that has been collected on a national standard form called a UB-92, for the purpose of billing third party organizations for reimbursement.
This billing data was not collected for clinical purposes from which one could easily
make judgements about patient care. Acknowledging the constraints and limitations of
the THCIC process, to the best of our knowledge the THCIC data are reasonable representations of the administrative data except for two items that merit specific
comment.

Standard/Non-Standard Sources of Payment
This data is not contained within the national standard UB-92 record used for billing.
Therefore, additional programming was required to capture and provide the specified
categories of payment. The effectiveness of this programming will be monitored and
refined on a go-forward basis to achieve an appropriate degree of accuracy in the data.

Age Classification of Patients
The data reflect several occurrences of highly unusual reported ages of patients in
the Normal Newborn, Vaginal Delivery and Neonate categories and we cannot attest to
the accuracy of this suspect data. We are researching these variances in an effort
to determine the cause for the aberrations in reported ages.

==========

THCIC ID: 115000 / Rosewood Medical Center
QUARTER: 4
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 4th Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

==========

THCIC ID: 118000 / St Lukes Episcopal Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

The data reports for quarter 4, 1999 do not accurately reflect patient volume, severity, or patient origin.

Patient Volume
Data reflects administrative claims data (Uniform Billing data elements) that are a snapshot of claims one month following quarter-end. If the encounter has not yet been billed, data will not be reflected in this quarter.

Even though source of payment will not be released for the quarter, a programming issue with payor sources was identified during the extraction of the data. THCIC's requirement for data submission is that a claim be produced. At St. Luke's Episcopal Hospital, a claim is not produced on self-pay patients. As a result, this payor source was inadvertently omitted. Once identified, it was too late to correct for this release.

Severity
Descriptors for newborn admissions are based on nation billing data elements (UB92) and definitions of each element can and do vary from hospital to hospital. Because of the absense of universal definitions for normal delivery, premature delivery, and sick baby, this category cannot be used for comparison across hospitals. The DRG is the only somewhat meaningful description of the infant population born at a facility.
More importantly, not all clinically significant conditions can be captured and reflected in the various billing data elements including the ICD-9-CM diagnosis coding system such as ejection fraction. As a result, the true clinical picture of the patient population cannot be adequately demonstrated using admissions and billing data.

Patient Origin
Because of a mapping issue with resident area in our population, the data incorrectly reflects that we had no out of country patients during the quarter. Our out of country patients are in fact counted in the out of state numbers. This was recognized too late to be corrected. Corrected demographics would reveal the following:
Quarter 4, 1999:
Out of country patients = 161
Out of state patients = 251

==========

THCIC ID: 119000 / Memorial Hospital Southeast
QUARTER: 4
YEAR: 1999

Certified with comments

All discharges with an admit type of newborn have an admission source of normal delivery versus a combination of normal delivery, premature delivery, sick baby, and extramural birth. These admission sources will not appear until June 2000 data. All newborns are, however, represented accurately by diagnoses and procedure codes.

==========

THCIC ID: 129000 / Memorial Medical Center East Texas
QUARTER: 4th
YEAR: 1999

Certified with comments

16% of physicians responded to THCIC data.
Of this 16%:
4% elected not to review the data
1% found an error in the description of a diagnosis
5% found the information, to the best of their knowledge, to be accurate.
6% Returned the form with no response indicated.

We believe all data to be accurate to the best of our knowledge.

==========
THCIC ID: 130000 / Providence Memorial Hospital
 QUARTER: 4
    YEAR: 1999

Certified with comments

Discharge Disposition Clarification

The discharge disposition 06 is inclusive of patients discharged home with home health and those discharged home with hospice. Discharge disposition 50, should have been used for those patients being sent home with hospice.
==========
THCIC ID: 134000 / Northeast Baptist Hospital
 QUARTER: 4
    YEAR: 1999

Certified with comments

Comments:
This is administrative data that has been collected on a national standard form called a UB-92, for the purpose of billing third party organizations for reimbursement.
This billing data was not collected for clinical purposes from which one could easily
make judgements about patient care. Acknowledging the constraints and limitations of
the THCIC process, to the best of our knowledge the THCIC data are reasonable representations of the administrative data except for two items that merit specific comment.

Standard/Non-Standard Sources of Payment
This data is not contained within the national standard UB-92 record used for billing.
Therefore, additional programming was required to capture and provide the specified
categories of payment. The effectiveness of this programming will be monitored and
refined on a go-forward basis to achieve an appropriate degree of accuracy in the data.

Age Classification of Patients
The data reflect several occurrences of highly unusual reported ages of patients in
the Normal Newborn, Vaginal Delivery and Neonate categories and we cannot attest to
the accuracy of this suspect data.   We are researching these variances in an effort
to determine the cause for the aberrations in reported ages.
==========
THCIC ID: 140000 / Edinburg Regional Medical Center
 QUARTER: 4
    YEAR: 1999

Certified with comments

Physician license numbers and names have been validated with the physician and

the websites as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

==========

THCIC ID: 141000 / Navarro Regional Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Navarro Regional Hospital is an acute, general medical-surgical hospital with the additonal services of a Skilled Nursing Facility and an Acute Rehabilitation Unit. The data in the public release file may or may not adequately allow separation of patients in the acute hospital from those in the other two units. Admixture of all three units can lead to increases for acute hospitals alone. It is notable that 13 of the 47 deaths in the fourth quarter of 1999 occurred in the two non-acute units, and that in at least 33 of the deaths, the patient or family members had requested that full efforts to maintain life not be pursued (Advanced Directive, Living Will or Do Not Resuscitate orders).

==========

THCIC ID: 142000 / Margaret Jonsson Charlton Methodist Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

DATA CONTENT
This data is administrative data, which hospitals collect for billing purposes, and not clinical
data, from which you can make judgements about patient care. The data submitted are certified
to be accurate representations of the billing data recorded, to the best of our knowledge. The
data is not certified to represent the complete set of data available on all inpatients but rather that
data which was reported to a particular payer as required by that payer.

PHYSICIAN REVIEW OF THE DATA
Physicians admitting inpatients to Charlton, from time to time, review physician specific data
that is generated from our internal computer systems. Charlton did not attempt to have
every physician individually review each patient in the actual data set returned to us by the State.
We matched the State generated reports to internally generated reports to ensure data submission
accuracy. We then reviewed these reports with Physician leadership who assisted us in
generating the comments contained herein.

SUBMISSION TIMING
The State requires us to submit a snapshot of billed claims, extracted from our database
approximately 20 days following the close of the calendar year quarter. Any discharged patient
encounters not billed by this cut-off date will not be included in the quarterly submission. Claims

billed in the subsequent quarter for discharges of a previous quarter will be submitted to the State
in the subsequent quarter's submission.

It should also be noted that the payer might deny all or part of a bill for which an adjustment
might be made on our internal data systems. The process of appealing a denied claim or service
and coming to final resolution can take as long as a year to resolve with a payer. Obviously any
outcome of these processes would not be reflected in a quarter's data.

OMISSION OF OBSERVATION PATIENTS
The reported data only include inpatient status cases. For various conditions, such as chest pain,
there are observation patients that are treated effectively in a short non-inpatient stay and are
never admitted into an inpatient status. The ratio for Charlton Methodist Hospital is about 1
observation patient for every 10 inpatients. Thus, calculations of inpatient volumes and length of
stay may not include all patients treated in our hospital.

DIAGNOSIS AND PROCEDURES
The state and billing regulations require us to submit diagnoses and procedures in ICD-9-CM
standard codes. The hospital can code up to 25 diagnosis codes and 25 procedure codes. The
state data submission requirements limit us to the first nine diagnosis codes and the first six
procedure codes. As a result, the data sent by us do meet state requirements but may not reflect
all the codes an individual patient's record may have been assigned. Approximately 13% of
Charlton Methodist Hospital's patient population have more than nine diagnoses and/or six
procedures assigned.

Therefore, those patients with multiple diseases and conditions (more diagnoses and procedures)
are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which
treat sicker patients, are likewise less accurately reflected. Further, true total volumes for a
diagnosis or procedure may not be represented by the State's data file, which therefore make
percentage calculations such as mortality rates or severity of illness adjustments inaccurate.

Charlton Methodist Hospital adheres to national coding standards but it should be noted that
coding cannot establish cause and effect (ie. Infection coded, but does not identify whether
present upon admission or developed in-house; fall coded, but does not identify whether the fall
occurred prior to or during hospitalizations.). It is also difficult to distinguish between a co-

morbidity and a complication.

NORMAL NEWBORNS
Admission Source or Admission Type codes are not the best way to reflect the pre-maturity or illness of an infant. Per State data submission regulation, if Admission Type is coded as a "newborn" then Admit Source is a code used to delineate the type of birth as "normal newborn" "premature delivery" "sick baby" and "extra-mural birth." Admission type is a code used to classify a baby as a newborn only if the baby was actually born in the reporting hospital. A very sick baby, transferred from another hospital or facility will be coded as an Admission Type of "Emergency" and Admission Source of "Xfer from Hospital." The actual conditions and experiences of an infant in our facility are captured elsewhere in the data file, namely, in the ICD-9-CM diagnoses and procedures codes.

ADMIT SOURCE
Charlton Methodist Hospital does not currently use all of the codes that are available in the State data. Specifically we are not actively collecting data that stratifies the type of facility a patient came from in the event of a transfer from another healthcare facility.

RACE AND ETHNICITY CODES
We are concerned about the accuracy of the State mandated race and ethnicity codes. Some patients decline to answer our inquiries about their race or ethnic classification. We certify that the race and ethnicity codes we submit represent nothing more than the patient's own classification or our best judgment.

STANDARD/NON-STANDARD SOURCE OF PAYMENT
The standard and non-standard source of payment codes are an example of data required by the State that is not contained within the standard UB92 billing record. In order to meet this requirement each payer's identification must be categorized into the appropriate standard and non-standard source of payment value. It is important to note that sometimes, many months after billing and THCIC data submission, a provider may be informed of a retroactive change in a patient's eligibility for a particular payer. This will cause the Source of Payment data to be inaccurate as reported in the quarter's snapshot of the data. The categories most effected are "Self Pay" and "Charity" shifting to "Medicaid" eligible.

REVENUE CODE AND CHARGE DATA
The charge data submitted by revenue code represents Methodist's charge structure, which may

or may not be the same for a particular procedure or supply as another provider.

CAUTION ON THE USE OF DATA WITH SMALL NUMBERS OF CASES IN PERCENTAGE COMPARISONS
Besides the data limitations mentioned above, the number of cases that aggregate into a
particular diagnosis, procedure or Diagnosis Related Grouping could render percentage
calculations statistically non-significant if the number of cases is too small.

SEVERITY ADJUSTMENT SCORES
THCIC is responsible for providing and maintaining a tool to assign an All-patient Refined
(APR) Diagnosis Related Group (DRG) severity score for each encounter at their data processing
center. Charlton Methodist Hospital neither creates nor submits the APR DRG contained in the
data sets.

==========

THCIC ID: 145000 / University Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

This data represents accurate information at the time of certification.
Subsequent changes may continue to occur that will not be reflected in
this published dataset.

==========

THCIC ID: 146000 / Covenant Hospital Plainview
QUARTER: 4
YEAR: 1999

Certified with comments

The data reviewed by hospital staff and physicians appears, to the best
of our knowledge, to be correct and accurate.

It is the practice of the hospital to review all unusual occurrences or
length of stay cases via the medical staff's peer review process.

Outliers seen in this quarter's data have been reviewed by appropriate
medical staff.

==========

THCIC ID: 158000 / University Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

DATA CORRECTION - PLEASE NOTE BEFORE PERFORMING ANY MORTALITY CALCULATIONS
USING THIS DATA.

As part of University Hospital's internal quality control procedures,
data was audited to check for accuracy and completeness. After data was
submitted to the Texas Health Care Information Council for public release,
an error was noted in regard to patient discharge status which impacts
606 patient records. 606 patients in the 4th Quarter 1999 were given

an initial discharge status classification value of 42 ("Expired - Place Unknown (to be used for Medicare Outpatients)"). These discharge dispositions were updated by medical records after deadlines required for submitting claims data to the state.

Please note the following description of the patient discharge status for the 606 patient records impacted (the value, description, count and percent of total for the 606 records are shown):

01	Discharged to home/self care (routine)	559	(92.2%)
02	Discharged/Xfer to another short term general hosp	9	(1.5%)
03	Discharged/Xfer to skilled nursing facility	5	(0.8%)
04	Discharged/Xfer to intermediate care facility	1	(0.2%)
05	Discharged/Xfer to other type of inst (dist part incl)	10	(1.7%)
06	Discharged/Xfer to home under care of health service	4	(0.7%)
07	Left against medical advice	1	(0.2%)
20	Expired (or didn't recover - Christian Sci patient)	17	(2.8%)

PLEASE NOTE THIS CORRECTION WHEN PERFORMING ANY CALCULATIONS IN REGARD TO THE HOSPITAL MORTALITY RATE. Please direct any questions you may have regarding this data correction to Kirk Black at (210) 358-2335.

DATA CONTENT

This data is administrative data that hospitals collect for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality. The state requires submission of inpatient claims, by quarter year, gathered from a form called a UB92, in a standard government format called HCFA 1450 EDI electronic claim format. The state specifications require additional data elements to be included over and above that. Adding these additional data elements places programming burdens on the hospital since it is data not included in the actual hospital billing process. Errors can occur due to this additional programming.

SUBMISSION TIMING

University Health System estimates that our data volumes for the calendar year time period submitted may include 96% to 100% of all cases for that time period. The state requires submission of billed claims extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this deadline date are not included in the quarterly submission file sent in.

DIAGNOSIS AND PROCEDURES

The data submitted matches the state's reporting requirements but may be incomplete
due to a limitation on the number of diagnoses and procedures
the state allows us to include for each patient. The state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed. Approximately 15% of University Health System's patient population have more than nine diagnoses and/ or six procedures assigned.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government and all

hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is a code does not exist for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state requires submission of ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by University Health System meets state requirements but cannot reflect all the codes an individual patient's record may have been assigned. Accurate total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). Sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format.

LENGTH OF STAY

The length of stay data element contained in the state's certification file is only three characters long. Thus any patient discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

NORMAL NEWBORNS

The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. University Health System's normal hospital registration process defaults "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

RACE/ETHNICITY

During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race data element is subjectively captured and the ethnicity data element is derived from the race designation. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Analysis of these two data fields does not accurately describe the true population served by the hospital.

STANDARD/NON-STANDARD SOURCE OF PAYMENT

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92

billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. Additionally, those payers identified contractually as both "HMO and PPO" are categorized as "Commercial PPO." Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

At the time of data submission, a high percentage of discharges categorized as "self-pay" are pending eligibility for another funding source, including Medicare, Medicaid and CareLink (a program supported by the Bexar County Hospital District tax division). By the time the data is released, the status for approximately 90% of "self-pay" discharges have changed to one of these funding sources.

COST/ REVENUE CODES

The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care each patient needs.

CERTIFICATION PROCESS

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not complete and thorough at this time. During the current certification phase, University Health System did not have an efficient mechanism to edit and correct the data. In addition, due to University Health System's volume, it is not feasible to perform encounter level audits.

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THCIC ID: 164000 / The Institute for Rehabilitation & Research
QUARTER: 4
YEAR: 1999

Certified with comments

*TIRR (The Institute for Rehabilitation and Research) was founded in 1959 in Houston's Texas Medical Center by William A. Spencer, MD. Dr. Spencer articulated a rehabilitation philosophy of maximizing independence and quality of life that continues to guide the development of our programs. This guiding philosophy includes providing appropriate medical intervention, helping the patient establish realistic goals and objectives, and supporting the patient to maintain personal integrity and family and social ties. TIRR is an internationally known, fully accredited teaching hospital that specializes in medical care, education and research in the field of catastrophic injury. It has been recognized every year in a nationwide survey of physicians by U.S. News & World Report as one of the best hospitals in America.

The hospital's research into developing improved treatment procedures has substantially reduced secondary complications of catastrophic injuries as well as average lengths of stay. TIRR is one of only three hospitals in the country that has Model Systems designation for both its spinal cord and brain injury programs.

Our programs are outcome-oriented with standardized functional scales by which to measure a patient's progress. Some of these programs are:

Spinal Cord Injury. Since 1959, TIRR has served over 3,000 patients with spinal cord injuries and has built an international reputation as a leader in innovative treatment, education and research. TIRR was one of the first centers to be designated by NIDRR (National Institute on Disability and Rehabilitation Research) as a regional model spinal cord injury system for exemplary patient management and research, a designation
it has maintained since 1972.

Brain Injury. The Brain Injury Program at TIRR admits patients who have brain injuries resulting from trauma, stroke, tumor, progressive disease, or metabolic dysfunction. The Program is designated as a Model System for Rehabilitation for Persons with Traumatic Brain Injury by the NIDRR and as a Rehabilitation Research and Training Center on Rehabilitation Interventions Following Traumatic Brain Injury.

Amputee. The Amputee Program serves patients with traumatic amputations, congenital limb deficiencies, and disease related amputations. TIRR is uniquely experienced in complex multiple limb loss associated with trauma and electrical burns and with amputations associated with diabetes mellitus and peripheral vascular disease.

Comprehensive Rehabilitation. TIRR's skills and expertise in caring for patients with central nervous system disorders such as spinal cord injury and brain injury transfer well to those admitted to the comprehensive rehabilitation program who may also have some weakness or loss of sensation, coordination or mobility. This program serves patients with diagnoses including simple and multiple fractures, arthritis, deconditioning
after medical complex disorders, multiple sclerosis, post-polio syndrome, complications from burns, etc.

Pediatric Program. The Pediatric Program at TIRR admits children with congenital or acquired physical and/or cognitive impairments. The program usually treats children from infancy to 16 years of age.

In reviewing the THCIC data for 4th quarter 1999, we discovered that the patient discharge status mapped incorrectly to "Other Institution" instead of "Home or Self Care" in 11 cases. This changes our statistics to:

Patient Discharge Status	No. Patients	% of Total Admissions
Discharge to Home or Self Care	169	80.48%
Discharge/Transfer to Gen. Hospital	8	3.81%
Discharge/Transfer to SNF	4	1.90%
Discharge to ICF	4	1.90%
Discharge/Transfer to Other Institution	18	8.57%
Discharge/Transfer to Home Health	6	2.86%
Left AMA	1	.48%

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THCIC ID: 168000 / Shannon West Texas Memorial Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Physician names are incorrect in some instances but they do have the correct

Texas license number.

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THCIC ID: 181000 / Medical Center Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

For Dec. 99, we are short about 460 accounts from what there should be. We had several problems with 99 data and one of the reasons was because we had to restore files from backups and create special programs to build the data. We have since created programs to capture the data starting with the year 2000 data. For the majority of the accounts the problems should be fixed on year 2000 and 2001 claims.

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THCIC ID: 182000 / Harris Methodist H.E.B.
QUARTER: 4
YEAR: 1999

Certified with comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Diagnosis and Procedures

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An "apples to apples" comparison cannot be made
which makes it difficult to obtain an accurate comparison of hospital or physician performance.

The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission, or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 10.9% of Harris Methodist HEB's patient population have more than nine diagnoses and/ or
six procedures assigned.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Admit Source data for Normal Newborn
When the Admit type is equal to "newborn", the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus

on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to "normal delivery" as the admission source. Therefore, admission source does not always give an accurate picture.

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. THR recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity
During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race and ethnicity data elements are subjectively captured. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identification must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information,
because those payers identified contractually as both "HMO, and PPO" are categorized as "Commercial PPO". Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Currently, Harris Methodist HEB has classified Workmen's Compensation to be included in "Commercial". This will be modified in the future. For 4th quarter 1999 there were 8 Workmens Compensation inpatients.

Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

Certification Process
Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and as thorough as all parties would like to see in the future. Within the constraints of the current THCIC process the data is certified to the best of our knowledge as accurate.
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THCIC ID: 188000 / Bellaire Medical Center
 QUARTER: 4
    YEAR: 1999

Certified with comments

1) The length of stay information is affected by our skilled nursing unit population. Our length of stay for the fourth quarter of 1999 is 4.53 excluding the skilled nursing population.
2) The relationship between the cost of care, charges and the revenue that a facility receives is extremely complex. Inferences to comparing costs of care from one hospital to the next may result in unreliable results.
3) The data is administrative/claims data, not clinical. This carries inherent limitations to using it to compare outcomes.

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THCIC ID: 191000 / Texoma Medical Center
 QUARTER: 4
    YEAR: 1999

Certified with comments

Data Source. The source of this data, the electronic 1450, is administrative in nature, and was collected for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality.
- The 1450 data file limits the diagnosis codes to nine (principal plus eight secondary diagnosis codes); the admission diagnosis and an E-code field.
- The procedure codes are limited to six (principal plus five secondary).
- The fewer the codes the less information is available to evaluate the patient's outcomes and service utilization.
- The Hospital can only list 4 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

Payer Codes. The payer codes utilized in the THCIC data base were defined by the state. They are not utilizing the standard payer information from the claim.

Revenue Codes and Charges. Charges associated with the 1450 data do not represent actual payments or costs for services.

Severity Adjustment. THCIC is using the 3M APR-DRG system to assign the All-Patient Refined (APR) DRG, severity and risk of mortality scores. The scores represent a categorization of patient severity and mortality risk. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status.
- The program can only use the codes available in the 1450 data file, e.g., nine diagnosis and six procedure codes. If all the patient's diagnosis codes were available the assignment may be different than when limited to those available in the 1450 data.

Timing of Data Collection. Hospitals must submit data to THCIC no later than 60 days after the close of the quarter.
- Not all claims may have been billed at this time.
- Internal data may be updated later and appear different than the data on the claim. Unless the payment is impacted, the hospitals does not rebill when a data field is changed internally. This results in differences

between internal systems and the snapshot of data that was taken at the end of the quarter.

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THCIC ID: 191001 / Reba McEntire Center for Rehabilitation
QUARTER: 4
YEAR: 1999

Certified with comments

Data Source. The source of this data, the electronic 1450, is administrative in nature, and was collected for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality.
- The 1450 data file limits the diagnosis codes to nine (principal plus eight secondary diagnosis codes); the admission diagnosis and an E-code field.
- The procedure codes are limited to six (principal plus five secondary).
- The fewer the codes the less information is available to evaluate the patient's outcomes and service utilization.
- The Hospital can only list 4 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

Payer Codes. The payer codes utilized in the THCIC data base were defined by the state. They are not utilizing the standard payer information from the claim.

Revenue Codes and Charges. Charges associated with the 1450 data do not represent actual payments or costs for services.

Severity Adjustment. THCIC is using the 3M APR-DRG system to assign the All-Patient Refined (APR) DRG, severity and risk of mortality scores. The scores represent a categorization of patient severity and mortality risk. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status.
- The program can only use the codes available in the 1450 data file, e.g., nine diagnosis and six procedure codes. If all the patient's diagnosis codes were available the assignment may be different than when limited to those available in the 1450 data.

Timing of Data Collection. Hospitals must submit data to THCIC no later than 60 days after the close of the quarter.
- Not all claims may have been billed at this time.
- Internal data may be updated later and appear different than the data on the claim. Unless the payment is impacted, the hospitals does not rebill when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

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THCIC ID: 191002 / Texoma Medical Center Behavioral Health Center
QUARTER: 4
YEAR: 1999

Certified with comments

Data Source. The source of this data, the electronic 1450, is administrative in nature, and was collected for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality.

- The 1450 data file limits the diagnosis codes to nine (principal plus eight secondary diagnosis codes); the admission diagnosis and an E-code field.
- The procedure codes are limited to six (principal plus five secondary).
- The fewer the codes the less information is available to evaluate the patient's outcomes and service utilization.
- The Hospital can only list 4 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

Payer Codes. The payer codes utilized in the THCIC data base were defined by the state. They are not utilizing the standard payer information from the claim.

Revenue Codes and Charges. Charges associated with the 1450 data do not represent actual payments or costs for services.

Severity Adjustment. THCIC is using the 3M APR-DRG system to assign the All-Patient Refined (APR) DRG, severity and risk of mortality scores. The scores represent a categorization of patient severity and mortality risk. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status.
- The program can only use the codes available in the 1450 data file, e.g., nine diagnosis and six procedure codes. If all the patient's diagnosis codes were available the assignment may be different than when limited to those available in the 1450 data.

Timing of Data Collection. Hospitals must submit data to THCIC no later than 60 days after the close of the quarter.
- Not all claims may have been billed at this time.
- Internal data may be updated later and appear different than the data on the claim. Unless the payment is impacted, the hospitals does not rebill when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

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THCIC ID: 191004 / Texoma Restorative Care SNF
QUARTER: 4
YEAR: 1999

Certified with comments

Data Source. The source of this data, the electronic 1450, is administrative in nature, and was collected for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality.
- The 1450 data file limits the diagnosis codes to nine (principal plus eight secondary diagnosis codes); the admission diagnosis and an E-code field.
- The procedure codes are limited to six (principal plus five secondary).
- The fewer the codes the less information is available to evaluate the patient's outcomes and service utilization.
- The Hospital can only list 4 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

Payer Codes. The payer codes utilized in the THCIC data base were defined by the state. They are not utilizing the standard payer information from

the claim.

Revenue Codes and Charges. Charges associated with the 1450 data do not represent actual payments or costs for services.

Severity Adjustment. THCIC is using the 3M APR-DRG system to assign the All-Patient Refined (APR) DRG, severity and risk of mortality scores. The scores represent a categorization of patient severity and mortality risk. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status.
- The program can only use the codes available in the 1450 data file, e.g., nine diagnosis and six procedure codes. If all the patient's diagnosis codes were available the assignment may be different than when limited to those available in the 1450 data.

Timing of Data Collection. Hospitals must submit data to THCIC no later than 60 days after the close of the quarter.
- Not all claims may have been billed at this time.
- Internal data may be updated later and appear different than the data on the claim. Unless the payment is impacted, the hospitals does not rebill when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

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THCIC ID: 206000 / Select Specialty Hospital - Houston Heights
QUARTER: 4
YEAR: 1999

Certified with comments

Discharge status errors -due to a mapping issue ; revised in 2000. Select Specialty Healthcare Management System software was set up to accept either alpha or numeric data.

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THCIC ID: 206002 / Select Specialty Hospital Houston Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

Error Record Message 871 E, Source Pay Code, F, Commerial, on THCIC Claim Corrections v.4.2.0 does not match HMS, Financial Class 7, Medicare HMO (Payors, e.g., Prudential Senior Care, Humana Gold Plus, Nylcare 65 St. Luke's Episcopal Hospital, etc.). These errors need to be edited in THCIC Claim Corrections to Source Pay Code, C, for Medicare.

Error Record Message 855 E, Alpha Patient Status, OS, OR, H2, H1, RC, OD, in HMS, Medical Record Abstracting does not match THCIC Claim Corrections Numerical Patient Status, 03, 05, 02, 02, 04, 02 respectively. These errors need to be edited also in the THCIC Claim Corrections.

Error Record Messages 863 W and 864 W, Social Security Number. When a patient is admitted, at times the SSN cannot be obtained from the patient or transferring hospital. These errors are irreversible.

Error Record Message 876 E must be addressed with Patient Accounting.

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THCIC ID: 214000 / Medical Center of Plano
 QUARTER: 4
    YEAR: 1999

Certified with comments

DOB- 11/22/37
DRG- 132

Please change marital status from single to widowed. Thanks.

Please accept this as our 4th qtr 1999 data submission, correction, and certification. Due to high employee turnover and hospital instability, this was not done in a timely and complete manner. We apologize for any inconviences that this may have caused. For 1st qtr 2000 we will however rectify the situation by working with Lorna and Diana so that we can reprocessed the data so that it is more accurate and reliable.
We have received a letter from Mr. Jim Lloyd, Executive Director, that the hospital will not be fined for 4th qtr 1999 and 1st qtr 2000. We would like to express our deepest gratitude to Mr. Lloyd for his understanding towards our hosptial's difficulties. We would also like to express our deepest gratitude for Ms. Diana McClenny for her support throughout this process. She truly represents what customer service and support is all about. Thank-you.
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THCIC ID: 228000 / Southwest General Hospital
 QUARTER: 4
    YEAR: 1999

Certified with comments

the warning is being reviewed by the billing office.
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THCIC ID: 229000 / Houston Northwest Medical Center
 QUARTER: 4
    YEAR: 1999

Certified with comments

1. Admit Type true value is 2,282 Emergency; 348 Urgent; 1,995 Elective; and 893 Newborn for 4th quarter 1999.

2. Admit Source 4th quarter 1999 true value is 3 Clinical Referral; 2,264 Emergency; 3,142 Physician Referral; 85 Transfer from Hospital; 11 Transfer from SNF; 4 Transfer from other Health Care facility; 1 Court/Law Enforcement; and 8 Transfer from Rehab/Substance Abuse.

3. Newborn code 4th quarter true value is 679 Normal Delivery; 66 Premature Delivery; and 148 Sick Babies.
==========
THCIC ID: 235000 / Harris Methodist Forth Worth
 QUARTER: 4
    YEAR: 1999

Certified with comments

CLINICAL DATA:

The THCIC data conforms to the HCFA 1450 file specifications. The 1450 data is administrative and collected for billing purposes. It is not clinical data and should be used cautiously to evaluate health care quality.

The 1450 data file limits the diagnosis codes to nine (principal plus eight secondary diagnosis codes); the admission diagnosis and an E-code field.

The use of E-Codes (i.e. injury source) is optional in Texas and Harris Methodist Fort Worth does not collect these codes in the trauma or motor vehicle admissions. This can result in erroneous evaluation of injury sources if researchers do not understand the limitations of this data field.

The procedure codes are limited to six (principal plus five secondary). The fewer the codes the less information is available to evaluate the patient's outcome and service utilization. When the patient has more codes in the medical record than allowed in the 1450 file, the hospital must select only nine diagnosis codes and six procedure codes. Hospitals populate these code fields differently.

Since there is this limited number of diagnosis and procedure codes used and no standardization on how hospitals are assigning them, there are obvious inherent problems with this data. Using this type of data to evaluate quality and outcomes cannot portray an accurate picture of quality measurements or outcomes.

THCIC is using 3M APR-DRG system to assign the All-Patient Refined (APR)DRG, severity and risk of mortality scores. The assignment is made by evaluation of the patient's age, sex, diagnosis and procedure codes and discharge status. This program can only use the codes available in the 1450 data file (i.e. the nine diagnosis and six procedure codes). If all the patient's diagnosis codes and procedure codes were available the assignment may be different that when limited to those available in the 1450 data.

ADMIT TYPE AND SOURCE:

Problems have been identified with newborn source codes. The data collection source for the THCIC newborn baby (i.e. normal delivery, premature, sick baby or extramural birth) is an admission code assigned by an admission clerk. This does not give an accurate description of the severity of illness in the newborn and the more precise area to collect this information would be in the infant's diagnosis codes assigned on discharge.

PAYOR CODES/COSTS:

The payor codes utilized in the THCIC database were defined by the state and are not using standard payor information from the claim. The mapping process of specific payors to the THCIC payor codes was not standardized by THCIC. Therefore, each hospital may map differently which can create variances in coding.

Few hospitals have been able to assign the "Charity" payor code in the data submitted to THCIC. Hospital are not able to determine whether or not charges will be considered "charity" until long after dismissal when all potential payment sources have been exhausted.

It is important to note that charges do not reflect actual payments to the hospital to deliver care, which are substantially reduced by managed care discounts, payor denials, and contractual allowances, as well as charity and uncollectable accounts.

RACE AND ETHNICITY:

Race and ethnicity codes are not required in the HCFA 1450 specifications, these data elements are unique to THCIC. Each hospital must independently map their specific codes to the state's race code categories.

The collection, documentation and coding of race and ethnicity vary considerably across hospitals. Some hospitals do not ask the patient, rather an admission clerk makes a subjective decision. Each hospital may designate a patient's race/ethnicity differently.

Many hospitals do not collect ethnicity as a separate category. They may collect race, e.g. Hispanic, which defaults to ethnicity and then to whatever the hospital has mapped for that category. The lack of standardization may result in apparently significant differences among hospitals reported racial mix, which are not valid or accurate.

SPECIALTY SERVICE:

The 1450 data does not have any specific data field to capture unit of service or to expand on the specialty service(s) provided to a patient. THCIC is using codes from the bill type and accommodation revenue codes in an attempt to distinguish specialty services.

Services used by and outcomes expected of patients on the hospice units,in rehab, in skilled nursing areas and other specialty areas are very different. The administrative data has inherent limitations and will impact the evaluation of health care services provided at Harris Methodist Fort Worth.

TIMING OF DATA COLLECTION:

Hospitals are required to submit data to THCIC no later than 60 days after the close of the quarter. Not all claims have been billed in this time period. Depending on how the data is collected and the timing of the billing cycle all hospital discharges may not be captured.

Internal data may be updated after submission and then will be different that the data submitted to THCIC. This makes it difficult to evaluate the accuracy and completeness of the THCIC data files against internal systems.

CERTIFICATION PROCESS:

Harris Methodist Fort Worth has policies and procedures in place to validate the accuracy of the discharge data and corrections submitted within the limitations previously stated. To the best of our knowledge, all errors and omissions currently known to the hospital have been corrected and data is accurate and complete.

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THCIC ID: 245000 / Dolly Vinsant Memorial Hospital
 QUARTER: 4

YEAR: 1999

Certified with comments

We certify that the patient data contained within these records are correct to the best of our knowledge.

The physician data however is incorrect. This was caused by a system reporting error that has since been corrected and physician future quarters will be correct

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THCIC ID: 252000 / Southwestern General Hospital
QUARTER: 4
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 4th Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

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THCIC ID: 255000 / Methodist Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

DATA CONTENT
This data is administrative data, which hospitals collect for billing purposes, and not clinical
data, from which you can make judgements about patient care. The data submitted are certified
to be accurate representations of the billing data recorded, to the best of our knowledge. The
data is not certified to represent the complete set of data available on all inpatients but rather that
data which was reported to a particular payer as required by that payer.

PHYSICIAN REVIEW OF THE DATA
Physicians admitting inpatients to Methodist, from time to time, review physician specific data
that is generated from our internal computer systems. Medical Center did not attempt to have
every physician individually review each patient in the actual data set returned to us by the State.
We matched the State generated reports to internally generated reports to ensure data submission
accuracy. We then reviewed these reports with Physician leadership who assisted us in
generating the comments contained herein.

SUBMISSION TIMING
The State requires us to submit a snapshot of billed claims, extracted from our database
approximately 20 days following the close of the calendar year quarter. Any discharged patient

encounters not billed by this cut-off date will not be included in the quarterly submission. Claims billed in the subsequent quarter for discharges of a previous quarter will be submitted to the State in the subsequent quarter's submission.

It should also be noted that the payer might deny all or part of a bill for which an adjustment might be made on our internal data systems. The process of appealing a denied claim or service and coming to final resolution can take as long as a year to resolve with a payer. Obviously any outcome of these processes would not be reflected in a quarter's data.

OMISSION OF OBSERVATION PATIENTS

The reported data only include inpatient status cases. For various conditions, such as chest pain, there are observation patients that are treated effectively in a short non-inpatient stay and are never admitted into an inpatient status. The ratio for Methodist Medical Center is about 1.73 observation patients for every 10 inpatients. Thus, calculations of inpatient volumes and length of stay may not include all patients treated in our hospital.

DIAGNOSIS AND PROCEDURES

The state and billing regulations require us to submit diagnoses and procedures in ICD-9-CM standard codes. The hospital can code up to 25 diagnosis codes and 25 procedure codes. The state data submission requirements limit us to the first nine diagnosis codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but may not reflect all the codes an individual patient's record may have been assigned. Approximately 20% of Methodist Medical Center's patient population have more than nine diagnoses and/or six procedures assigned.

Therefore, those patients with multiple diseases and conditions (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected. Further, true total volumes for a diagnosis or procedure may not be represented by the State's data file, which therefore make percentage calculations such as mortality rates or severity of illness adjustments inaccurate.

Methodist Medical Center adheres to national coding standards but it should be noted that coding cannot establish cause and effect (ie. Infection coded, but does not identify whether present upon admission or developed in-house; fall coded, but does not identify whether the fall occurred prior

to or during hospitalizations.). It is also difficult to distinguish between a co-morbidity and a complication.

NORMAL NEWBORNS

Admission Source or Admission Type codes are not the best way to reflect the pre-maturity or illness of an infant. Per State data submission regulation, if Admission Type is coded as a "newborn" then Admit Source is a code used to delineate the type of birth as "normal newborn" "premature delivery" "sick baby" and "extra-mural birth." Admission type is a code used to classify a baby as a newborn only if the baby was actually born in the reporting hospital. A very sick baby, transferred from another hospital or facility will be coded as an Admission Type of "Emergency" and Admission Source of "Xfer from Hospital." Methodist Medical Center operates a level 3 critical care nursery, which receives transfers from other facilities. The actual conditions and experiences of an infant in our facility are captured elsewhere in the data file, namely, in the ICD-9-CM diagnoses and procedures codes.

ADMIT SOURCE

Methodist Medical Center does not currently use all of the codes that are available in the State data. Specifically we are not actively collecting data that stratifies the type of facility a patient came from in the event of a transfer from another healthcare facility.

RACE AND ETHNICITY CODES

We are concerned about the accuracy of the State mandated race and ethnicity codes. Some patients decline to answer our inquiries about their race or ethnic classification. We certify that the race and ethnicity codes we submit represent nothing more than the patient's own classification or our best judgment.

STANDARD/NON-STANDARD SOURCE OF PAYMENT

The standard and non-standard source of payment codes are an example of data required by the State that is not contained within the standard UB92 billing record. In order to meet this requirement each payer's identification must be categorized into the appropriate standard and non-standard source of payment value. It is important to note that sometimes, many months after billing and THCIC data submission, a provider may be informed of a retroactive change in a patient's eligibility for a particular payer. This will cause the Source of Payment data to be inaccurate as reported in the quarter's snapshot of the data. The categories most effected are "Self Pay" and "Charity" shifting to "Medicaid" eligible.

REVENUE CODE AND CHARGE DATA
The charge data submitted by revenue code represents Methodist's charge structure, which may
or may not be the same for a particular procedure or supply as another provider.

CAUTION ON THE USE OF DATA WITH SMALL NUMBERS OF CASES IN PERCENTAGE COMPARISONS
Besides the data limitations mentioned above, the number of cases that aggregate into a
particular diagnosis, procedure or Diagnosis Related Grouping could render percentage
calculations statistically non-significant if the number of cases is too small.

SEVERITY ADJUSTMENT SCORES
THCIC is responsible for providing and maintaining a tool to assign an All-patient Refined
(APR) Diagnosis Related Group (DRG) severity score for each encounter at their data processing
center. Methodist Medical Center neither creates nor submits the APR DRG contained in the
data sets

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THCIC ID: 256000 / Harris Methodist Erath County
QUARTER: 4
YEAR: 1999

Certified with comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Diagnoses and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government.
The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia

until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An "apples to apples" comparison cannot be made which makes it difficult to obtain an accurate comparison of hospital or physician performance.

The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission, or developed an infection during their hospitalizaiton. This makes it difficult to obtain accurate information regarding things such as complication rates.

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 3% of Harris Methodist Erath County's patient population have more than nine diagnoses and/or six procedures assigned.

The ICD-9 codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us to meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Admission Source Data
The admission source indicates the location the patient is admitted from or the origin of the order to admit. In some instances, a patient may have two admission sources. The patient may be admitted through the emergency room from a nursing home. In this instance, there would be two admission sources. Ony one admission source can be assigned in the hospital information system, therefore, the state data reflects only one admission source. While the data submitted is correct, it does not display on accurate picture of all admission sources.

Admission Source Data for Normal Newborn
When the admit type is equal to "newborn", the admission source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to

focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admission source code. Many hospital information systems and registration process defaults to "normal delivery" as the admission source. Therefore, admission source does not always give an accurate picture.

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Harris Methodist Erath County recommends use of ICD-9-CM coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity
During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race and ethnicity data elements are subjectively captured. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories . This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Standard/Non-Standard Source of Payment
The standard and non-standard sources of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identification
must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identifed contractually as both "HMO, and PPO" are categorized as "Commercial PPO". Thus any true managed care comparison by contract type (HMO vs. PPO) may result in inaccurate analysis.

Cost/Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also no not reflect the acutal cost to deliver the care that each patient needs.

Certification Process
Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and as thorough as all parties would like to see in the future. Within the constraints of the current THCIC process the data is certified to the best of our knowledge as accurate.

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THCIC ID: 261000 / Northside General Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

DOB- 11/22/37
DRG- 132

Please change marital status from single to widowed. Thanks.

Please accept this as our 4th qtr 1999 data submission, correction, and certification. Due to high employee turnover and hospital instability, this was not done in a timely and complete manner. We apologize for any inconviences that this may have caused. For 1st qtr 2000 we will however rectify the situation by working with Lorna and Diana so that we can reprocessed the data so that it is more accurate and reliable.
We have received a letter from Mr. Jim Lloyd, Executive Director, that the hospital will not be fined for 4th qtr 1999 and 1st qtr 2000. We would like to express our deepest gratitude to Mr. Lloyd for his understanding towards our hosptial's difficulties. We would also like to express our deepest gratitude for Ms. Diana McClenny for her support throughout this process. She truly represents what customer service and support is all about. Thank-you.

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THCIC ID: 263000 / R.E. Thomason General Hospital
 QUARTER: 4
    YEAR: 1999

Certified with comments

NEWBORN ADMISSIONS

Errors in Newborn admissions were identified. Based on coding information the following are corrected figures.

Normal deliveries   = 933
Premature Deliveries = 94
Sick Babies   = 291
Extramural   = data not available

Total Newborns for 4Q99 = 1318

PAYOR MIX

Mapping problems were identified in primary payer source. The following is the corrected information.

CHARITY   = 423
COMMERCIAL = 385
MEDICAID   = 2385
MEDICARE   = 310
SELF PAY   = 856

Total Encounters = 4359

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THCIC ID: 266000 / Sierra Medical Center
 QUARTER: 4
    YEAR: 1999

Certified with comments

1. Admission Type: Elective
Elective admission category was previously not being captured. Data is being captured as of 11/1/00 and will be reflected with 4th Quarter 2000 data.

2. Admission Type: Unknown
Hospital data captured is not compatible with THCIC who currently utilizes UB92 definitions and format. Resolution is pending.

3. Admission Source
All Admission Source available data for Hospital was not being captured. Data is being captured as of 11/1/00 and will be reflected with 4th Quarter 2000 data.

4. Newborn Admissions
Newborn Admissions data reflects 544 encounters under category, "Information Not Available", which should be reflected under category, "Normal Delivery". This has been identified to be a mapping issue and currently is being addressed and resolution is scheduled to be in place for submission of 2001 Quarter 1 data.

5. Patient Discharge Status
All Patient Discharge Status data that is available to Hospital was not being captured. Additional data is being captured as of 7/1/00 and will be reflected with 3rd Quarter 2000 data.

6. Non-standard Source of Payment
Non-standard Source of Payment codes for Hospital do not match THCIC codes. Many of the Source Payment Codes have been classified by THCIC as Missing or Invalid. This has been identified to be mapping issue and is currently being addressed. Resolution is pending.

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THCIC ID: 267000 / Diagnostic Center Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

One account missing for Fourth Quarter 1999.

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THCIC ID: 285000 / Baylor Medical Center Ellis County
QUARTER: 4
YEAR: 1999

Certified with comments

Data Content
This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those

additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate; this was a unique, untried use of this data as far as hospitals are concerned.

Submission Timing
Baylor estimates that our data volumes for the calendar year time period submitted may include 96% to 100% of all cases for that time period. The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in.

Diagnosis and Procedures
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Normal Newborns

The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Baylor's normal hospital registration process defaults "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

Race/Ethnicity
During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race data element is subjectively captured and the ethnicity data element is derived from the race designation. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 97.8% of encounters originally categorized across all values have a different value as of today. Upon review an additional data issue was uncovered. All managed care encounters were categorized as "Commercial PPO" instead of separating the encounters into "HMO" versus "PPO".

Additionally, those payers identified contractually as both "HMO and PPO" are categorized as "Commercial PPO". Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

Certification Process
Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. During the current certification phase, Baylor did not have an efficient mechanism to edit and correct the data. In addition, due to the volume at Baylor, it is not feasible to perform encounter level audits.

YEAR: 1999

Certified with comments

Data Content
This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate; this was a unique, untried use of this data as far as hospitals are concerned.

Submission Timing
Baylor estimates that our data volumes for the calendar year time period submitted may include 96% to 100% of all cases for that time period. The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in.

Diagnosis and Procedures
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients

(more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Normal Newborns
The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Baylor's normal hospital registration process defaults "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

Race/Ethnicity
During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race data element is subjectively captured and the ethnicity data element is derived from the race designation. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Upon review, a mapping issue was uncovered regarding the categorization of "Hispanic" and "White" encounters. Approximately 14% of the "Hispanic" encounters were categorized under the state defined "Black" race code instead of the state defined "Other" race code. Approximately 71% of the "White" encounters were categorized under the state defined "Black" race code instead of the state defined "White" race code.

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 2.5% of encounters originally categorized as "Charity" have been re-categorized as "Blue Cross" or "Commercial".

Additionally, those payers identified contractually as both "HMO and PPO" are categorized as "Commercial PPO". Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Admission Source
Upon review of the certification data, a mapping error from the source

system values to the state defined values was uncovered. Approximately 38% of patient encounter records categorized with an Admission Source Code of "Xfer from Psych, Sub Abuse, Rehab Hosp" should have been categorized with an Admission Source code of "Emergency Room".

Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

Certification Process
Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. During the current certification phase, Baylor did not have an efficient mechanism to edit and correct he data. In addition, due to the volume at Baylor, it is not feasible to perform encounter level audits.

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THCIC ID: 303000 / Presbyterian Hospital of Kaufman
QUARTER: 4
YEAR: 1999

Certified with Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Diagnosis and Procedures

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital
using a universal standard called the International Classification of Disease, or ICD-9-CM.
This is mandated by the federal government. The hospital complies with the guidelines for
assigning these diagnosis codes, however, this is often driven by physician's subjective
criteria for defining a diagnosis. For example, while one physician may diagnose a patient
with anemia when the patient's blood hemoglobin level falls below 9.5, another physician
may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0.
In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by
the physician to determine that diagnosis was different. An "apples to apples" comparison
cannot be made which makes it difficult to obtain an accurate comparison of hospital or
physician performance.

The codes also do not distinguish between conditions present at the time of the patient's
admission to the hospital and those occurring during hospitalization. For example, if
a code indicating an infection is made, it is not always possible to determine if the
patient had an infection prior to admission, or developed an infection during their
hospitalization. This makes it difficult to obtain accurate information regarding
things such as complication rates.

The data submitted matches the state's reporting requirements but may be incomplete due
to a limitation on the number of diagnoses and procedures the state allows us to include
for each patient. In other words, the state's data file may not fully represent all
diagnoses treated by the hospital or all procedures performed, which can alter the true
picture of a patient's hospitalization, sometimes significantly. Approximately 6% of
PRESBYTERIAN HOSPITAL OF KAUFMAN's patient population have more than nine diagnoses assigned.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital
using a universal standard called the International Classification of Disease, or ICD-9-CM.
This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by
hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures

for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Admit Source data for Normal Newborn
When the Admit type is equal to "newborn", the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to "normal delivery" as the admission source. Therefore, admission source does not always give an accurate picture.

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick

babies mixed in with the normal newborn data. PRESBYTERIAN HOSPITAL OF KAUFMAN recommends
use of ICD9 coding data to identify neonates. This methodology will ensure correct
identification of the clinical status of the newborn admission.

Race/Ethnicity
During the hospital's registration process, the registration clerk does not routinely
inquire as to a patient's race and/or ethnicity. The race and ethnicity data elements
are subjectively captured. There are no national standards regarding patient race
categorization, and thus each hospital may designate a patient's race differently.
The state has recently attempted to standardize a valid set of race codes for this
project but these are not universally used by all hospitals. Each hospital must
independently map their specific codes to the state's race code categories. This mapping
may not be consistent across hospitals. Thus epidemiology analysis of these two data
fields does not accurately describe the true population served by the hospital.

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required
by the state that is not contained within the standard UB92 billing record. In order
to meet this requirement, each payer identification must be categorized into the appropriate
standard and non-standard source of payment value. These values might not accurately reflect
the hospital payer information,
because those payers identified contractually as both "HMO, and PPO" are categorized as
"Commercial PPO". Thus any true managed care comparisons by contract type (HMO vs. PPO)
may result in inaccurate analysis.

Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is
important to note that charges are not equal to actual payments received by the hospital
or hospital cost for performing the service. Typically actual payments are much less than
charges due to managed care-negotiated discounts and denial of payment by insurance
companies. Charges also do not reflect the actual cost to deliver the care that each
patient needs.

Bill Types
Due to data export considerations, all inpatient's are designated as bill type 111.

This includes all skilled nursing admissions should be designated as bill type 211 and
221. The result is an overall LOS that is slightly increased.

Certification Process
Due to the infancy of the state reporting process and the state's computer system
development, the certification process is not as complete and as thorough as all parties would like to see in the future. Within the constraints of the current THCIC
process the data is certified to the best of our knowledge as accurate.

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THCIC ID: 315000 / Mesquite Community Hospital
QUARTER: 4
YEAR: 1999

Elect not to certify

February 1, 2001

Jim Loyd
Texas Health Care Information Council
4900 North Lamar Boulevard, Suite 3407
Austin, TX 78751-2399

Re: Hospital Discharge Data Certification Letter
Quarter Ending: December 1999

Dear Mr., Loyd,

I, Raymond P. De Blasi, Chief Executive Officer at Mesquite Community Hospital, elect not to certify the returned data due to the reasons stated below and as stated previously in our prior 1999 quarterly certification letters.

Errors in coding such as Admission Type, Newborn Admissions, Patient Race and Operating Physician have been identified. We now have mechanisms for correction being developed and in place for all identified errors on current quarterly submissions.

If you have questions, please call me at (972) 698-2523.

Sincerely,

Raymond P. De Blasi
Chief Executive Officer

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THCIC ID: 319000 / Del Sol Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

We have a Anthesiologist that is showing up as the Operating Physcian.
We need to have our Vendor map this differently in the 80 record so he
Shows up as Other Physician.

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THCIC ID: 323000 / Walls Regional Hospital
 QUARTER: 4
    YEAR: 1999

Certified with Comments:

Data Content
Walls Regional Hospital collects this data for billing purposes therefore, it is limited in describing a complete clinical encounter.

Diagnosis and Procedures
Walls Regional Hospital patients are coded by diagnoses and procedures for a particular
hospital stay using a universal standard called the International Classification of
Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals
must comply.

The codes are assigned based on documentation in the patient's chart and are used by
hospitals for billing purposes. The data submitted matches the state's reporting requirement, which is limited to 9 diagnoses and 6 procedures. In other words, the state's data file may not fully represent all diagnoses treated by the hospital
or all procedures performed, because of the limitation on diagnosis and procedures.
This can alter the true picture of a patient's hospitalization, sometimes significantly.
Approximately 10% of Walls patient population have more than nine diagnoses and/or six
procedures assigned.
One limitation of using the ICD-9-CM system is that there does not exist a code for
every possible diagnosis and procedure due to the continued evolution of medicine.
New codes are added yearly as coding manuals are updated.

This means also that true total volumes may not be represented by the state's data file,
which therefore make percentage calculations inaccurate (i.e., mortality percentages for
any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Race/Ethnicity
During the hospital's registration process, the registration clerk does not routinely

inquire as to a patient's race and/or ethnicity. The race and ethnicity data elements
are subjectively captured. There are no national standards regarding patient race
categorization, and thus each hospital may designate a patient's race differently.
The state has recently attempted to standardize a valid set of race codes for this
project but
these are not universally used by all hospitals. Therefore, until that occurs the
epidemiology analysis of these two data fields does not accurately describe the true
population served by the hospital.

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required
by the state that is not contained within the standard UB92 billing record. In order
to meet this requirement, each payer identification must be categorized into the
appropriate standard and non-standard source of payment value. These values might
not accurately reflect the hospital payer information, because those payers identified
contractually as both "HMO and PPO" are categorized as "Commercial PPO". Thus any true
managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate
analysis.

Due to mapping limitations, Workers' Compensation and Blue Cross claims are understated
and it is hoped this will be corrected in the future.

Walls Regional Hospital grants Charity based on approved criteria. However, that decision
is made after discharge and is not reflected in the Standard Source of Payment.
For example, Self-pay will often eventually be granted Charity but this report is
mapped on discharge data prior to that determination hence, Charity on this report is
not accurate.

Certification Process
This is a new program to Walls and the state therefore, the certification process is
not as complete and as thorough as all parties expect it will be in the future. With
this understanding of the current THCIC process, the data is certified to the best of
our knowledge as accurate.

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THCIC ID: 331000 / Baylor University Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

Data Content
This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate; this was a unique, untried use of this data as far as hospitals are concerned.

Submission Timing
Baylor estimates that our data volumes for the calendar year time period submitted may include 96% to 100% of all cases for that time period. The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in.

Diagnosis and Procedures
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 20 % of Baylor's patient population have more than nine diagnoses and/ or six procedures assigned.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450

format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Normal Newborns
The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Baylor's normal hospital registration process defaults "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

Race/Ethnicity
During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race data element is subjectively captured and the ethnicity data element is derived from the race designation. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Upon review of the certification data, it was found that 5% of the "White" encounters were incorrectly categorized as "Other".

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record might change over time. Upon review approximately 5% of Baylor encounters originally categorized as "Medicare" have been recategorized as "Commercial".

Additionally, those payers identified contractually as both "HMO, and PPO" are categorized as "Commercial PPO". Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each

patient needs.

Certification Process
Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. During the current certification phase, Baylor did not have an efficient mechanism to edit and correct the data. In addition, due to Baylor's volume, it is not feasible to perform encounter level audits.

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THCIC ID: 332000 / Cook Childrens Medical Center
QUARTER: 4
YEAR: 1999

Elect not to certify

We have elected to not certify the fourth quarter 1999 discharge encounter data as returned by the Texas Health Care Information Council for the following reason:

The data structure allowed by THCIC erroneously assigns surgeons to surgical procedures they did not perform. The data structure provided by THCIC allows for one attending and one operating physician assignment. However, patients frequently undergo multiple surgeries where different physicians perform multiple procedures. Assigning all of those procedures to a single 'operating physician' will frequently attribute surgeries to the wrong physician. THCIC chooses to only assign one surgeon to a patient encounter, not to each procedure.

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THCIC ID: 335000 / Ascension Health - Brackenridge Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

As the public teaching hospital in Austin and Travis County, Brackenridge serves patients who are often unable to access primary care. It is more likely that these patients will present in the later more complex stage of their disease. Brackenridge has a perinatal program that serves a population that includes mothers with late or no prenatal care. Brackenridge is also a regional referral center, receiving patient transfers from hospitals not able to serve a complex mix of patients. Treatment of these very complex, seriously ill patients increases the hospital's costs of care, lengths of stay and mortality rates.

As the Regional Trauma Center, Brackenridge serves severely injured patients. Lengths of stay and mortality rates are most appropriately compared to other trauma centers.

Admission Source - Newborn Data
Brackenridge Hospital experienced a data collection problem affecting the admit source field when the admit type is 4 (Newborn). As a result of this collection problem, 844 of the 849 newborn admissions to Brackenridge were reported as normal delivery, and no premature newborns were reported. The hospital is correcting the data collection problem prospectively, but corrections will not affect data previously submitted.

Race and ethnicity data are self-reported by patients and are not independently verified by the hospital.

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THCIC ID: 335001 / Childrens Hospital of Austin
QUARTER: 4
YEAR: 1999

Certified with comments

Children's Hospital of Austin is the only children's hospital in the Central Texas Region. Children's serves severely ill and/or injured children requiring intensive resources which increases the hospital's costs of care, lengths of stay and mortality rates. In addition, the hospital includes a Neonatal Intensive Care Unit (NICU) which serves very seriously ill infants, which substantially increases costs of care, lengths of stay and mortality rates.

Admission Source - Newborn Data
Children's Hospital of Austin Center experienced a data collection problem affecting the admit source field when the admit type is 4 (Newborn). As a result of this collection problem, 35 of the 76 newborn admissions to Children's were reported as normal delivery, and no premature newborns were reported. The hospital is correcting the data collection problem prospectively, but corrections will not affect data previously submitted.

Race and ethnicity data are self-reported by patients and are not independently verified by the hospital.

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THCIC ID: 336001 / Denton Regional Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

When reviewing the data for Denton Regional Medical Center, please consider the following:

The data is administrative/claims data, not clinical research data. There may be inherent limitations to using it to compare outcomes.

The cost of care, charges, and the revenue a facility receives is extremely complex. Inferences to comparing costs of care from one hospital to another may result in unreliable results.

All statistics for Denton Regional include Skilled Nursing, Rehabilitation, and Geriatric Psychiatry, which are long-term care units, in addition to acute care services. This will preclude any meaningful comparisions between Denton Regional Medical Center and and "acute care services only" provider.

Admission source data is not collected and grouped at Denton Regional in the same manner as displayed.

Lengths of stay statistics are higher, as a result of patient stays in our long-term care units.

Elderly individuals are more apt to utilize the long-term inpatient services

provided by Denton Regional. This is reflected in the patient age breakdown.

Under the Standard Source of Payment, please note that statistics in the "Commercial" category also include managed care providers.

The severity grouping assignment performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper. Denton Regional is unable to comment on the accuracy of this report.

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THCIC ID: 337000 / West Houston Medical Center
 QUARTER: 4
    YEAR: 1999

Certified with comments

Included in the discharge encounter data are discharges from our Skilled Nursing unit, Rehabilitation Unit, Geropsychiatric Unit, and medical Hospice service which may skew length of stay, deaths, and charge data.

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THCIC ID: 340000 / Medical City Dallas Hospital
 QUARTER: 4
    YEAR: 1999

Certified with comments

MCDH treats high risk neonatal, pediatric and transplant patients. SNF and REHAB patient data included. Diagnostic and procedure information not comprehensive.

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THCIC ID: 345000 / Doctors Memorial Hospital
 QUARTER: 4
    YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 4th Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

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THCIC ID: 390000 / Park Plaza Hospital
 QUARTER: 4
    YEAR: 1999

Certified with comments

DATA SUBMISSION

The data included in the fourth quarter 1999 submission to the State is considered
administrative data collected by Park Plaza Hospital for billing purposes and not
used to make judgements about patient care. On a quarterly basis we submit only inpatient UB92 data to the State. The UB 92 is a standard billing form that all hospitals use to submit claims to payors. The information is submitted in a standard
government format called HCFA 1450 EDI electronic claim format. The data must be

submitted by the 20th day following the close of the quarter. Any accounts in the quarter not billed by the deadline will not be reflected in this data. In addition, it is important to note that the UB92 claim form only allows nine diagnoses and six procedure codes to be submitted. In addition only three physicians can be identified; attending physician, and two other physicians. Anyone evaluating this data should understand that our diagnoses/procedure data collection system allows us to enter twelve diagnoses codes, ten procedure codes and identify up to ten physicians. The additional diagnoses and procedures may have an impact on the severity level and APR/DRG assigned to the admission. Therefore the physician data, severity level and APR/DRG assignments reported for some of these admissions may not be accurate.

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THCIC ID: 392000 / Nacogdoches Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

DATA Content
This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called a UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate; this was a unique, untried use of this data as far as hospitals are concerned.

Submission Timing
The hospital estimates that our data volumes for the calendar year time period submitted may include 96% to 100% of all cases for that time period. The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in.

Diagnosis and Procedures

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of the patient's hospitalization, sometimes significantly.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, Or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedures codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes in an individual patient's record which may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness). It would be obvious, therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Specialty Services
The data submitted does not have any specific data field to capture unit of service or expand in the specialty service (such as rehab) provided to a patient. Services used by patients in rehab may be very different from those used in other specialties.

The data is limited in its ability to categorize patient type.

Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay as long as or longer than 999 days, therefore, it is not anticipated that this limitation will affect this data. The hospital does provide oncology services. The length of stay for this patient population is generally longer compared to other acute care patients. This may skew the data when combined with other acute care patient stays.

Normal Newborns
The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. The hospital's normal hospital registration process defaults "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

Race/Ethnicity
During the hospital's registration process, the registration clerk does routinely complete patient's race and/or ethnicity field. The race data element is sometimes subjectively captured and the ethnicity data element is derived from the race designation.
There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals.
Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Cost/Revenue
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the

hospital cost for performing the service. Typically actual payments are much less
than charges due to negotiated discounts with 3rd party payors. Charges also do not
reflect the actual costs to deliver the care that each patient needs.

Certification Process
Due to the infancy of the state reporting process and the state's computer system
development, the certification process is not as complete and thorough at this time,
as all parties would like to see in the future. During the current certification
phase, the hospital did not have an efficient mechanism to edit and correct the data.
In addition, it is not feasible to perform encounter level audits at this time.
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THCIC ID: 394000 / Medical Center of Lewisville
QUARTER: 4
YEAR: 1999

Certified with comments

1. This data is administrative and claims data only. It is not clinical research data.
There may be inherent limitations in using this data to compare clinical outcomes.

2. This data only contains a subset of the diagnoses and procedure codes. This limits
the ability to access all of the diagnoses and procedures relative to each patient.

3. The relationship between the cost of patient care, charges, and the payment that a
facility receives is very complex. Inferences made in comparing the cost of patient
care, charges, and payments form one hospital to another may result in unreliable results.

4. The severity grouping assignments performed by the state using the APR-DRG grouper
cannot be replicated by facilities unless they purchase this grouper. Also, the lack
of knowledge regarding how this grouper calculates the severity adjustments can greatly
impact the interpretation of the data.

5. There is great uncertainty about how physician linkages will be done across hospitals.

6. Race and ethnicity classification is not done systematically within, or between,
facilities. Caution should be used when analyzing this data within one facility and
when comparing one facility to another.

7. This data includes skilled nursing patients. The average length of stay for a
skilled nursing patient is normally higher than that of an acute care patient.

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THCIC ID: 396000 / Nix Health Care System
QUARTER: 4
YEAR: 1999

Certified with comments

Due to computer software mapping and logic problems, incorrect values are documented in the following three categories: Admission Source, Newborn Admissions, and Patient Race. Solutions are being investigated and implemented in order to provide correct information for future data submission.

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THCIC ID: 398000 / CHRISTUS Spohn Memorial Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Hospital Discharge Data Certification
Comment Attachment for 398000: CHRISTUS Spohn Hospital Memorial

CHRISTUS Spohn Hospital Memorial is a Level III Regional Trauma Center serving a twelve county region.

CHRISTUS Spohn Hospital Memorial is a teaching hospital with a Family Practice Residency Program based at the hospital.

The discharge encounter data returned to the Texas Health Care Information Council for calendar quarter fourth/1999 represents the patient population of CHRISTUS Spohn Hospital Memorial with an accuracy rate of 98%.

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THCIC ID: 407000 / Memorial Hermann Southwest Hospital
QUARTER: 4
YEAR: 1999

Certified without comments

97% of newborn admissions are represented as normal deliveries versus the combination of normal delivery, premature delivery, sick baby, and extramural birth. These admission sources will not appear consistently until June 2000 data. All newborns are, however, represented accurately by diagnoses and procedure codes.

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THCIC ID: 409000 / John Peter Smith Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

JPS Health Network
Comments on THCIC Data Submission
for
Quarter 4 1999

Introduction

John Peter Smith Hospital (JPSH) is operated by the JPS Health Network under the auspices of the Tarrant County Hospital District. The JPS Health Network is accredited by the Joint Commission on Accreditation of Health Care Organizations as an integrated health network. In addition, JPSH holds JCAHO accreditation as a hospital.

JPSH was the first Texas Department of Health certified Level II Trauma Center in Tarrant County and includes the only 24-hour, seven-day a week psychiatric emergency center in the area. The hospital's special services include intensive care for adults and newborns, a special AIDS treatment center, a skilled nursing unit, a full-range of obstetrical and gynecological services, inpatient care for patients of all ages and an inpatient mental health treatment facility.

JPSH is a major teaching hospital offering or providing through co-operative arrangements postdoctoral training in family medicine, orthopedics, obstetrics and gynecology, psychiatry, surgery, oral and maxillofacial surgery and podiatry.

In addition to JPSH, the JPS Health Network operates community-based health centers located in medically underserved areas of Tarrant County, a home health agency, school-based health centers, special outpatient programs for substance abusing pregnant women and a wide range of wellness education programs. A free medical information service, InfoNurseâ, is staffed 24 hours a day, seven days a week by licensed nurses.

Data Comments

This inpatient data was submitted to meet requirements of the State of Texas for reporting fourth quarter 1999 inpatient hospital discharge data. The data used by Texas Health Care Information Council (THCIC) is administrative
and collected for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality. Also, the use of only one quarter's data to infer statistical meaning can lead to misinterpretation.

Payer Source

The care of many JPS indigent patients is financed from county taxes. These patients are categorized in the field "non-standard source of payment" as charity.

Physician Master File

A patient may have several attending physicians throughout his/her course of stay due to the rotation of physicians to accommodate teaching responsibilities. This rotation may result in an under-representation of true attending physicians.

System Mappings

Within our current mainframe information system, we are unable to map certain discharge dispositions. These include patient discharges to non-skilled nursing homes, home health with I.V., and hospice care.

Diagnoses and Procedures
The data submitted matches the State's reporting requirements but may be incomplete due to a limitation on the number of diagnosis and procedure codes the State allows for each patient. Some patients may have greater than nine diagnoses or more than six procedures performed. This limitation can affect any comparisons.

Length of Stay
Some of our patients require increased length of stay. Reasons for increased length of stay are:
· JPSH is a major trauma center, many patients have suffered multiple system trauma.
· JPSH operates a SNF (skilled nursing facility) unit.
· JPSH operates an inpatient psychiatric unit in which many patients are court-committed and length of stay is determined by the legal system.
· Many of our patients have limited financial resources. This, in turn, often limits their discharge options.

AMA (Against Medical Advice)
Under most circumstances, patients have the right to discontinue treatment, including hospitalization, when he/she chooses. Sometimes, even after the physician has explained the benefits of the proposed treatment, a patient may still decide to leave the hospital. Research is currently being conducted to better understand the demographics of those patients who decide to leave before being officially dismissed.

Summary
All known errors were corrected or accounted for to the best of our ability, consistent with the limited time span allotted to all hospitals for the process. As we progress through the process of quarterly State filing and certification, JPSH is addressing the operational and mapping issues to improve the accuracy of the data reported to THCIC. JPSH will continue in its endeavor of continual quality improvement.

We are certifying the State data file, with comments.

Physician Comments
Prior to submission of this data physicians and other medical staff providers were given a reasonable opportunity to review the discharge files for which they were listed as the attending or treating physician. The aggregate comments of the physicians follow:
· Charts under this report relate to the fourth calendar quarter of 1999. Due to the extended time elapsing between the delivery of care and the submission of this report it is difficult to recall if all patients are correctly listed under the appropriate treating or attending physician.
· JPSH cares for an indigent population, which often has limited resources to transfer care to home care agencies, skilled nursing units or nursing homes. This may produce an increase in the reported length of stay while outpatient resources are developed to which care can be transferred.
· JPSH functions as a regional receiving facility for trauma. The admission of patients with complicated multi-system injuries increases hospital costs and hospitalization needs beyond that which may be seen with facilities that do not function as regional trauma referral sites.
· JPSH is a teaching facility. As such, the attending physicians rotate among the established services. This rotation may result in some inpatients not having a single attending staff for the duration of the hospital episode.

· Some physicians noted that they believed they had more admissions during the reporting period than that listed on the report. Other physicians in the same practice group may have been listed as the attending physician for more patients than they actually attended.
· Some physicians noted being incorrectly identified as the attending physician on some cases.

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THCIC ID: 417000 / United Regional Health Care System - 8th Street
QUARTER: 4
YEAR: 1999

Certified with comments

Data Content
This data is incomplete in that approximately 7% of our patient records are not included. Many of the missing records have a Source of Payment marked Self-Pay or Special Handling (Charity, Indigent, etc). Since records in the state data file are captured during the billing process and records marked Self-Pay or Special Handling do not go through the billing process they were not included in the file. There are some records which were not included because they had not been billed (and therefore had not gone through the billing process) prior to the cut-off date for data submission to the state.

Source of Payment
The Source of Payment was broken down into the Standard Source of Payment. The Non-Standard Source of Payment, which includes a breakdown by Managed Care, PPO, and HMO information, was not captured.

Newborn Admissions
The state pulls newborn admission statistics from the admission source code rather the final diagnosis code. The final diagnosis code provides a more appropriate reflection of the newborn's condition as the admission source is entered at registration when the status of the newborn is unknown.

Diagnosis/Procedure Codes
Patient records may be incomplete in that the number of diagnosis and procedure codes we can include in the state file is limited. A patient may have many more codes within the hospital database which, in turn, reflects a more precise picture of the patient's condition.

Certification Process
The state reporting process as well as the computer system development for state reporting by hospitals is in its infancy. Therefore, the state reporting data is not as complete and thorough as it will be in the future. Conclusions regarding patient care or hospital practices should not be drawn from the data contained in this file.

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THCIC ID: 422000 / Arlington Memorial Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical

details of an encounter.

The state requires hospitals to submit inpatient claims, by quarter year, gathered from a form called a UB92, in a standard government format called HCFA 1450 EDI electronic claim format. The state specifications require additional data elements to be included over and above that. Adding those additional data items places programming and other operational burdens on the hospital since it is "over and above" the data required in the actual hospital billing process. Errors can occur because of this process, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of the hospital's knowledge.

If a medical record is unavailable for coding, the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The hospital complies with the guidelines for assigning these diagnosis codes. However, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An "apples to apples" comparison cannot be made, making it difficult to obtain an accurate comparison of hospital or physician performance.

The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is assigned, it is not always possible to determine if the patient had an infection prior to admission, or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows hospitals to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.

The hospital can code an unlimited number of diagnoses and procedures for each patient record. But, the state has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by the hospital do meet state requirements

but cannot reflect all the codes an individual patient's record may have been assigned. This also means that true total volumes may not be represented in the state's data file, therefore making percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category

Race/Ethnicity
During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's ethnicity. In fact, there is not a field for ethnicity in the hospital's computer system. Therefore, all patients are being reported in the "Other" ethnicity category.

Race is an element the hospital does attempt to collect at admission. However, many patients refuse to answer this question and therefore, the registration clerks are forced to use their best judgment or answer unknown to this question.

Any assumptions based on race or ethnicity will be inaccurate.

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identification must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified correctly in the hospital's computer system as both "HMO, and PPO" are categorized as "Commercial PPO" in the state
file. Thus any true managed care comparisons by contract type (HMO vs.PPO) may result
in inaccurate analysis.

Revenue
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received. Typically actual payments are much less than charges due to bad debts, charity adjustments, managed care-negotiated discounts, denial of payment by insurance companies and government programs which pay less than billed charges.

Charity Care
THCIC assumes charity patients are identified in advance and reports charges in a charity financial class as the amount of charity care provided in a given period. In actuality, charity patients are usually not identified until after care has been provided and in the hospital's computer system charity care is recorded as an adjustment to the patient account, not in a separate financial class. Therefore, the THCIC database shows no charity care provided by the hospital for the quarter when in fact the hospital provided over $4,482,203 in charity care during this time period.
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THCIC ID: 426000 / El Campo Memorial Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

For the fourth quarter of 1999 there were 189 claims submitted. Of these

189 no claims were denied with error codes. Only two claims were included on this report due to info code 992. This computes to a 0% error rate which requires no corrections. With this in mind we are certifying our fourth quarter of 1999 data with the above comments.

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THCIC ID: 429000 / CHRISTUS Spohn Hospital Beeville
 QUARTER: 4
    YEAR: 1999

Certified with comments

Within a 99.5% confidence level.

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THCIC ID: 431000 / Presbyterian Hospital of Dallas
 QUARTER: 4
    YEAR: 1999

Certified with Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-9-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient

with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An "apples to apples" comparison cannot be made which makes it difficult to obtain an accurate comparison of hospital or physician performance.

The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission, or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 11% of PRESBYTERIAN HOSPITAL OF DALLAS's patient population have more than nine diagnoses.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned.

This means also that true total volumes may not be represented by the state's data
file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, those sicker patients
(more diagnoses and procedures) are less accurately reflected by the 1450 format.
It then stands to reason that hospitals, which treat sicker patients, are likewise
less accurately reflected.

Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database.
It is rare that patients stay longer than 999 days, therefore, it is not anticipated
that this limitation will affect this data.

Admit Source data for Normal Newborn
When the Admit type is equal to "newborn", the admit source should indicate whether
the baby was a normal newborn, premature delivery, sick baby, extramural birth, or
information not available. The best way to focus on severity of illness regarding
an infant would be to check the infant's diagnosis at discharge, not the admitting
source code. Many hospital information systems and registration process defaults to "normal delivery" as the admission source. Therefore, admission source does not
always give an accurate picture.

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature
and sick babies mixed in with the normal newborn data. PRESBYTERIAN HOSPITAL OF DALLAS
recommends use of ICD9 coding data to identify neonates. This methodology will ensure
correct identification of the clinical status of the newborn admission.

Race/Ethnicity
During the hospital's registration process, the registration clerk does not routinely
inquire as to a patient's race and/or ethnicity. The race and ethnicity data elements
are subjectively captured. There are no national standards regarding patient race
categorization, and thus each hospital may designate a patient's race differently.
The state has recently attempted to standardize a valid set of race codes for this
project but these are not universally used by all hospitals. Each hospital must

independently map their specific codes to the state's race code categories. This
mapping may not be consistent across hospitals. Thus epidemiology analysis of these
two data fields does not accurately describe the true population served by the hospital.

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required
by the state that is not contained within the standard UB92 billing record. In order
to meet this requirement, each payer identification must be categorized into the
appropriate standard and non-standard source of payment value. These values might
not accurately reflect the hospital payer information, because those payers
identified contractually as both "HMO, and PPO" are categorized as "Commercial PPO".
Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in
inaccurate analysis.

Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It
is important to note that charges are not equal to actual payments received by the
hospital or hospital cost for performing the service. Typically actual payments are
much less than charges due to managed care-negotiated discounts and denial of payment
by insurance companies. Charges also do not reflect the actual cost to deliver the
care that each patient needs.

Bill Types
Due to data export considerations, all inpatient's are designated as bill type 111.
This includes all skilled nursing admissions should be designated as bill type 211
and 221. The result is an overall LOS that is slightly increased.

Certification Process
Due to the infancy of the state reporting process and the state's computer system
development, the certification process is not as complete and as thorough as all
parties would like to see in the future. Within the constraints of the current THCIC
process the data is certified to the best of our knowledge as accurate.

Physician Comments to the data set:
Under the present system the length of stay, morbidity, and/or mortality may be
incorrectly attributed to provider "A" when in fact the length of stay, morbidity,
and/or mortality are related to procedure "B" or unrelated to any procedure.
Bassett B. Kilgore, M.D.

Mortality and length of stay may be attributed to a diagnostic procedure physician
when grouping the data by primary procedure physician, when in fact the major reason
for the admission was unrelated, or a minor event in the admission. In this case scenario the procedure was diagnostic and not therapeutic.
Pat Fulgham, M.D.

Comments from Magella Healthcare Corporation-a Neonatology Group Practice:
Magella wishes to express their concern regarding data collection methodology being employed to fulfill the Texas State Mandate of 1997 for creation of a health care data warehouse. As Megella understands it, this process is being undertaken to gain useful information regarding health resource utilization and patient outcomes. Megella is a large group practice specializing in neonatology and perinatology services. The practice of neonatology is very much a team endeavor
and we believe that the current data collection and collation methodology will not
accurately reflect the true performance of the individual neonatologist of of the team of neonatology health care providers.

For neonatologists that work in group practices, the way this data is assigned to
specific physicians for attending and admitting physicians may not accurately reflect the physician that was responsible for the majority of the patient's care.
In neonatology, patients tend to be shared by the group of neonatologists, often on some kind of rotational basis. The admitting doctor may never care for a patient
after admission, several doctors might provide weekend or night-time support, or a
small subset of doctors might provide most of the day-time care while a different
subset of doctors do the night-time piece. Additionally, the term, "Operating Physician" is an inappropriate designation for a neonatologist (though neonatologist
do perform minor procedures). This is of particular concern should the "Operating
Physician" reports be compared to the more traditional "Attending Physician" reports. The comparison has very little if any value.
Ian M. Ratner, M.D. Chairman of the MAGELLA Healthcare Corporation

My concern is that a common procedure may be performed for different indications.
The mortality for an ethmoidectomy is very low when performed for chronic sinustitis,
however, when performed for mucormycosis it is very high. This is not related to surgical technique/care but the underlying disease mortality rate which is very high for mucormycosis. If the database does not reflect underlying pathology accurately
then data will be worthless.
John R. Gilmore, M.D.
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THCIC ID: 438000 / East Texas Medical Center Pittsburg
 QUARTER: 4
    YEAR: 1999

Certify with Comments

The data for those Medicare patients that had a Skill Nursing hospital stay in the hospital's "Swing Bed" immediately after the Acute care hospital stay, is combined with the Acute Care hospital stay data. Therefore, the total length of the hospital stay will be longer than those Medicare patients who did not have a Skill Nursing hospital stay in a "Swing Bed".

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THCIC ID: 444000 / CHRISTUS St Elizabeth Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Currently validating attending 1st operating surgeon with hospital process for assignment

Admission screenflow for newborn admissions has been updated to include field for admission source. Not reflective on current data.

Charity assignments are incorrect -- revising process.

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THCIC ID: 445000 / Shannon Medical Center St Johns Campus
QUARTER: 4
YEAR: 1999

Certified with comments

Physician names are incorrect in some instances but they do have the correct Texas license number.

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THCIC ID: 446000 / Presbyterian Hospital of Winnsboro
QUARTER: 4
YEAR: 1999

Certified with Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.

The state requires us to submit inpatient claims, by quarter year, gathered from a
form called an UB92, in a standard government format called HCFA 1450 EDI electronic
claim format. Then the state specifications require additional data elements to be
included over and above that. Adding those additional data places programming burdens
on the hospital since it is "over and above" the actual hospital billing process.
Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been
corrected to the best of our knowledge.

If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Patient Population Characteristics
Presbyterian Hospital of Winnsboro's patient population is an older patient population with a large percentage of Medicare patients. This will impact the acuity of our patient population and our mortality rates. As noted earlier, administrative data does not always accurately represent all clinical characteristics and may be deficient in representing the true acuity level of our patients.

Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-9-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0.
In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An "apples to apples" comparison cannot be made which makes it difficult to obtain an accurate comparison of hospital or physician performance.

The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission, or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
Approximately 5% of PRESBYTERIAN HOSPITAL OF WINNSBORO's patient population have more than nine diagnoses assigned.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Race/Ethnicity

During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race and ethnicity data elements are subjectively captured. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order

to meet this requirement, each payer identification must be categorized into the appropriate standard and non-standard source of payment value. These values might
not accurately reflect the hospital payer information,
because those payers identified contractually as both "HMO, and PPO" are categorized
as "Commercial PPO". Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

Bill Types
Due to data export considerations, all inpatient's are designated as bill type 111.
This includes all skilled nursing admissions should be designated as bill type 211
and 221. The result is an overall LOS that is slightly increased.

Certification Process
Due to the infancy of the state reporting process and the state's computer system
development, the certification process is not as complete and as thorough as all parties would like to see in the future. Within the constraints of the current THCIC process the data is certified to the best of our knowledge as accurate.

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THCIC ID: 448000 / St Paul Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

Data Content
This data is administrative data which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called a UB92, in a standard government format called HCFA 1450 EDI electronic claim format. In addition, the state specifications require additional data elements to be included over and above that. Adding these additional elements places programming burdens on the hospital since it is "over and above" the actual billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

Submission Timing
The state requires us to submit a snapshot of billed claims extracted from our database approximately 40 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in. This

represents approximately 1% of the encounter volume.

Specialty Services
The 1450 data does not have a specific data field to capture unit of service or to expand on the specialty services provided to a patient. St. Paul's hospital characteristics are provided by using codes from bill type and accommodation revenue codes in an attempt to distinguish, at the patient level, use of specialty services. Services used by and outcomes expected of patients in our hospice, NICU, rehab, transplant, psychiatric and skilled nursing facility beds are very different and the administrative data has inherent limitations.

Diagnosis and Procedures
The data submitted matches the state's reporting requirements but may be incomplete due to the limited number of diagnosis and procedure codes the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 14% of St. Paul's patient population have more than eight diagnoses and/or six procedures assigned.

The state requires us to submit ICD-9-CM data on each patient but has limited the number of diagnosis and procedures to the first eight diagnosis codes and the first six procedure codes. This means also that true total volumes may not be represented by the state's data file which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnoses or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, that the sicker patients are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Patient diagnosis and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. The federal government mandates this and all hospitals must comply. The codes are assigned based on documentation in the patient's medical record and are used by hospitals for billing purposes. St. Paul complies with the guidelines for assigning these diagnosis codes; however, this is often driven by a physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An "apples to apples" comparison cannot be made which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.

Race/Ethnicity
The race and ethnicity data elements are subjectively captured and the ethnicity element is derived from the race designation. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by this hospital.
There are no national standards regarding patient race categorization, thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories and this mapping may not be consistent across hospitals.

Standard/Non-Standard Source of Payment
The standard and non-standard sources of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. Each hospital must independently map their specific codes to the state's payer information categories (there are no standards for this process) thus the mapping may be inconsistent across hospitals. Also, these values might not accurately reflect the hospital payer information because those payers identified contractually as both "HMO and "PPO" are categorized as "Commercial PPO". Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Certification Process
Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough, at this time, as all parties would like to see in the future.
St. Paul Medical Center has policies and procedures in place to validate and assure the accuracy of the discharge encounter data submitted. We have provided physicians a reasonable opportunity to review the discharge data of patients for which they were the attending or treating physician. To the best of our knowledge the data submitted is accurate and complete.

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THCIC ID: 449000 / RHD Memorial Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

DATA Content
This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called a UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate; this was a unique, untried use of this data as far as hospitals are concerned.

Submission Timing
The hospital estimates that our data volumes for the calendar year time period submitted may include 96% to 100% of all cases for that time period.

The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in.

Diagnosis and Procedures
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of the patient's hospitalization, sometimes significantly.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedures codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes in an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Specialty Services
The data submitted does not have any specific data field to capture unit of service or expand in the specialty service (such as rehab) provided to a patient. Services used by patients in rehab may be very different from those used in other specialties. The data is limited in its ability to categorize patient type.

Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay as long as or longer than 999 days, therefore, it is not anticipated that this limitation will affect this data. The hospital does have an inpatient rehabilitation unit whose patients stay an average of 12 days. This may skew the data when combined with other acute care patient stays.

Normal Newborns

The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. The hospital's normal hospital registration process defaults "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

Race/Ethnicity
During the hospital's registration process, the registration clerk does routinely complete patient's race and/or ethnicity field. The race data element is sometimes subjectively captured and the ethnicity data element is derived from the race designation. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Cost/Revenue
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to negotiated discounts with 3rd party payors. Charges also do not reflect the actual costs to deliver the care that each patient needs.

Certification Process
Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. During the current certification phase, the hospital did not have an efficient mechanism to edit and correct the data. In addition, it is not feasible to perform encounter level audits at this time.

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THCIC ID: 453000
QUARTER: 4
YEAR: 1999

Certified with comments

DeTar Hospital has a Skilled Nursing Unit which has been in operation since 1988.

DeTar Hospital also maintains a Rehabilitation Unit which has been in operation since 1991.

DeTar Hospital had a Geriatric-Psychiatry Unit in operation, but was closed effective September 20, 1999.

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THCIC ID: 459000 / Ben Taub General Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

The physicians or other health care providers involved in the treatment of the patients have not reviewed the attached data. The District understands that the physician data will not be released to the public for the 4th quarter of 1999.

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THCIC ID: 465000 / Covenant Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

Data does not accurately reflect the hospital's newborn population.
Total Births = 466
Live = 354
Premature = 112

Data does not accurately reflect the number of charity cases for the time period.
This is due to internal processing for determination of the source of payment.
4% of total discharges were charity for 4 Quarter 1999.

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THCIC ID: 469000 / Harris Methodist Northwest
QUARTER: 4
YEAR: 1999

Certified with comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government.
The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls

below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An "apples to apples" comparison cannot be made which makes it difficult to obtain an accurate comparison of hospital or physician performance.

The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission, or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Race/Ethnicity
During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race and ethnicity data elements are subjectively captured. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of

data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identification must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both "HMO, and PPO"
are categorized as "Commercial PPO". Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

Certification Process
Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and as thorough as all parties would like to see in the future. Within the constraints of the current THCIC process the data is certified to the best of our knowledge as accurate.

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THCIC ID: 474000 / Parkland Memorial Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

General Information
Parkland Health & Hospital System comprises a network of neighborhood-based health centers and Parkland Memorial Hospital, which was established in 1894 to care for the city's poor.

Today, the hospital is often ranked among the 25 best hospitals in the United States - public or private. Due to Parkland's affiliation with the University of Texas Southwestern Medical Center, the finest in medical care is now available to all Dallas County residents.

The Parkland system is a $675.9 million enterprise that is licensed for 990 beds and employs about 5,500 staff. It's Trauma Center is internationally
renowned for excellence and many other medical services are equally state of the art including: burn treatment, epilepsy, kidney/pancreas transplants, cardiovascular services, diabetes treatment, gasteroenterology, radiology, neonatal intensive care, and high risk pregnancy.

The hospital delivers more babies than any other hospital in the United States - 15,181 babies in fiscal year 2000. The hospital's Burn Center was established in 1962, and since then has treated more burn patients than any other civilian burn center in the world.

In 1964, the hospital performed the first kidney transplant in Texas. Since then, it's transplant success among African- Americans is the nation's best.

Parkland's innovative approach to providing community responsive health care in Dallas County has resulted in many service honors including: the Foster G. McGraw Award for Excellence in Community Service, the John P. McGovern Humanitarian Medicine Award, and a Public Service Excellence

Award from the Public Employees Roundtable.

Parkland's network of neighborhood-based health centers are based in low-income areas to ensure the poor have access to preventive health care. The network, called "Community Oriented Primary Care," was established in 1989, and now there are nine such centers.

In addition to the health care professionals who staff the clinics, many of the locations also have social service agencies located under the same roof - providing a one-stop-shopping approach to health services.

Specific Concerns

There is a concern at Parkland - as with other reporting hospitals - that there is no ethnicity category for Hispanics. A significant number of Parkland's patients are Hispanic, yet according to the data set, they are classified as either White-Hispanic or Black-Hispanic. The data set for reporting needs to provide a category for this ethnicity to accurately reflect the hospital's demographics.

==========

THCIC ID: 478000 / Memorial Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

In general the summary data is acceptable; however, a number of data quality errors are unresolved: facility records indicate 163 more births than shown on the report and mapping errors continue to be identified causing inaccurate reporting of race, admission source and attending physician.

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THCIC ID: 480000 / Knapp Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

KNAPP MEDICAL CENTER THCIC DISCLAIMER STATEMENT AND COMMENTS FOR FOURTH QUARTER 1999

DISCLAIMER STATEMENT

Knapp Medical Center has compiled the information set forth above in compliance with the procedures for THCIC certification process. All information that is being submitted has been obtained from Knapp Medical Center's records. The information being provided by Knapp Medical Center is believed to be true and accurate at the time of this submission. The information being submitted has been taken from other records kept by Knapp Medical Center and the codes typically used in those records do not conform to the codes required in THCIC certification process. Knapp Medical Center has used its best efforts and submits this information in good faith compliance with THCIC certification process. Any variances or discrepancies in the information provided is the

result of Knapp Medical Center's good faith effort to conform the information regularly
compiled with the information sought by THCIC.

ETHNICITY COMMENT FOR FOURTH QUARTER 1999

Ethnicity data for the fourth quarter of 1999 does not reflect the diversity of the
population served by Knapp Medical Center. The data indicates that in a region with a
high population of Hispanics, of 3605 discharges none were of Hispanic origin. Analysis
indicated a data-mapping problem in regards to the initial admission input for all patients,
inherent in the system we use. This is not correctable for prior periods, however changes
in the admitting tables correcting this mapping problem have been implemented.

CHARITY COMMENT

Knapp Medical Center has a long tradition of providing charity care for the population it
serves. Prior to designation as charity, program qualification attempts are exhausted.
This results in designation of charity being made after the patient is discharged,
sometimes many months. Patient specific charity amounts are not available, therefore, at
the time of submission of data to THCIC. Due to the impracticality at this time of
identifying specific patients designated as charity and submitting corrections, the
aggregate amount of charity provided during the fourth quarter 1999 was $972,613.01 for
70 patients.

PHYSICIAN COMMENTS
(Physicians are independent contractors. Comments made by physicians do not necessarily represent the views and opinions of Knapp Medical Center.)

Suggest Do Not Resuscitate be separated out.
Percentages are meaningless if inadequate population numbers; e.g. 48 total patients, 3
die, all of whom are terminal but this results in a 6% mortality rate.
==========
THCIC ID: 481000 / Woodland Heights Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

The data presented includes Skilled Nursing Inpatient Admission.
There is no way to distinguish the difference between Inpatient and
Skilled patients. This will reflect an Inaccurate Length of Stay on our

Acute Inpatients due to the fact that Skilled Nursing Facilities run longer
lenghts of stay. We are a major cardiovascular hospital within

a 100 mile radius.

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THCIC ID: 497000 / Ascension Health - Seton Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

Seton Medical Center has a transplant program and neonatal intensive care unit (NICU). Hospitals with transplant programs generally serve a more seriously ill patient, increasing costs and mortality rates. Neonatal Intensive Care Units serve very seriously ill infants substantially increasing costs, lengths of stay and mortality rates. As a regional referral center and tertiary care hospital for cardiac and critical care services, Seton Medical Center receives numerous transfers from hospitals not able to serve a more complex mix of patients. The increased patient complexity may lead to longer lengths of stay, higher costs and increased mortality.

Admission Source - Newborn Data
Seton Medical Center experienced a data collection problem affecting the admit source field when the admit type is 4 (Newborn). As a result of this collection problem, 1113 of 1116 newborn admissions at Seton were reported as "information not available", and no premature or normal newborns were reported. The hospital is correcting the data collection problem prospectively, but corrections will not affect data previously submitted.

Race and ethnicity data are self-reported by patients and are not independently verified by the hospital.

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THCIC ID: 497002 / Ascension Health - Seton Northwest Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Admission Source - Newborn Data
Seton Northwest Hospital experienced a data collection problem affecting the admit source field when the admit type is 4 (Newborn). As a result of this collection problem, 100% of the newborn admissions at Seton Northwest were reported as "information not available". The hospital is correcting the data collection problem prospectively, but corrections will not affect data previously submitted.

Race and ethnicity data are self-reported by patients and are not independently verified by the hospital.

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THCIC ID: 501000 / Dallas/Fort Worth Medical Center-Grand Prairie
QUARTER: 4
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 4th Quarter 1999. Review of the certification reports and data by THCIC identified the following errors or missing values:

- Patient discharge status is missing
- Source of standard and non-standard payment codes are missing

Patient race and ethnicity may not be valid
State codes are missing
Procedure codes are missing
External cause of injury is missing

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THCIC ID: 503000 / St Lukes Baptist Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Comments:
This is administrative data that has been collected on a national standard form called a UB-92, for the purpose of billing third party organizations for reimbursement.
This billing data was not collected for clinical purposes from which one could easily
make judgements about patient care. Acknowledging the constraints and limitations of
the THCIC process, to the best of our knowledge the THCIC data are reasonable representations of the administrative data except for two items that merit specific
comment.

Standard/Non-Standard Sources of Payment
This data is not contained within the national standard UB-92 record used for billing.
Therefore, additional programming was required to capture and provide the specified
categories of payment. The effectiveness of this programming will be monitored and
refined on a go-forward basis to achieve an appropriate degree of accuracy in the data.

Age Classification of Patients
The data reflect several occurrences of highly unusual reported ages of patients in
the Normal Newborn, Vaginal Delivery and Neonate categories and we cannot attest to
the accuracy of this suspect data. We are researching these variances in an effort
to determine the cause for the aberrations in reported ages.

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THCIC ID: 508000 / Conroe Regional Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

This data is administrative/claims data, not clinical research data.
There may be inherent limitations to using it to compare outcomes.

The public data will only contain a subset of the diagnosis and procedure codes, thus limiting the ability to access all of the diagnoses and procedures relative to each patient.

The relationship between cost of care, charges, and the revenue that a facility receives is extremely complex. Inferences to comparing costs of care from one hospital to the next may result in unreliable results.

Race/Ethnicity classification is not done systematically within or between facilities. Caution should be used when analyzing this data within one facility and between facilities.

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THCIC ID: 511000 / Doctors Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Data Content
This data is administrative data, collected by hospitals for billing purposes, and not clinical data, from which judgements about patient care can be made. The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. The state specifications then require additional data elements to be included over and above that. Adding those additional data elements places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate; this was a unique, untried use of this data as far as hospitals are concerned.

Submission Timing
Doctors Hospital estimates that our data volumes for the calendar year time period submitted include 92% of all cases for that time period. The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in. As a result, the state submitted data recognizes 2,134 incounters while Doctors Hospital's database reflects 2,328 encounters.

Diagnosis and Procedures
The data sumbitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 25% of the patient population serviced at Doctors Hospital has more than nine diagnosis and 15% have more than six procedures assigned to them.

Patient diagnosis and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

There is no limit to the number of diagnoses and procedure codes that can be assigned to a patient record. The codes are assigned based on

the physician's documentation in the patient's record and are used by hospitals for billing purposes. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine. New codes are added yearly as coding manuals are updated.

The state is required to submit ICD-9-CM data on each patient but has limited the number of diagnosis and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us does meet state requirements but does not reflect all the codes an individual patient's record may have been assigned. This means also that the true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, those sicker patients (more diagnosis and procedures) are less accurately reflected by the 1450 format. Many of the patients treated at Doctors Hospital are Do Not Resuscitate (DNR) patients or have Living Wills.

Normal Newborns
With this quarter's data, it was identified that newborns were not being mapped to an appropriate admit source. This was causing the majority of newborns to fall into an "information not available" admit source category. Upon further investigation, it was also identified this was not unique to Tenet hospitals but all Texas hospitals.

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identification must be categorized into the appropriate standard and non-standard source of payment value. Upon review of the data, the THCIC report shows almost twice as many cases as were reported by the Doctors Hospital charge breakout and summary report for Quarter 4, 1999. The greatest occurrence of error is with the Primary Commercial Pay category. The hospital database reflects 60 cases. The state data reflects 724 cases. Another area of concern is the Missing/Invalid Source of Payment under the Non-Standard Source of Payment field. The state recognizes 1221 cases. Doctors Hospital database indicates that there are no cases in this category. THCIC has recognized that there is a problem with the way this data is captured and will not be publishing it for Quarter 1, 1999 - Quarter 2, 2000. However, we would like to include in our comments that this data is invalid and therefore can not be considered accurate in any way.

Cost/Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically, actual payments are much less than charges due to managed care negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

Certification Process
Due to the infancy of the state reporting process and the state's computer system development, the certification process does not completely and accurately reflect all of the data that has been submitted. We have identified

areas of concern regarding the way information is mapped from our hospital to our submission agent, who in turn transmits data to THCIC. It also should be noted that due to high turnover in key areas of the hospital, we spent a great deal of time learning and relearning the process involved in submitting the THCIC data as well as preparing the data for submission.

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THCIC ID: 513000 / Baylor Medical Center Grapevine
QUARTER: 4
YEAR: 1999

Certified with comments

Data Content
This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate; this was a unique, untried use of this data as far as hospitals are concerned.

Submission Timing
Baylor estimates that our data volumes for the calendar year time period submitted may include 96% to 100% of all cases for that time period. The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in.

Diagnosis and Procedures
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but

has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Normal Newborns
The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Baylor's normal hospital registration process defaults "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

Race/Ethnicity
During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race data element is subjectively captured and the ethnicity data element is derived from the race designation. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 52.81% of encounters originally categorized across all values have a different value as of today. Upon review an additional data issue was uncovered. All managed care encounters were categorized as "Commercial PPO" instead of separating the encounters into "HMO" versus "PPO".

Additionally, those payers identified contractually as both "HMO and PPO" are categorized as "Commercial PPO". Thus any true managed care comparisons

by contract type (HMO vs. PPO) may result in inaccurate analysis.

Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

Certification Process
Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. During the current certification phase, Baylor did not have an efficient mechanism to edit and correct the data. In addition, due to the volume at Baylor, it is not feasible to perform encounter level audits.
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THCIC ID: 534001 / Memorial Hermann Katy Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Medicare and Medicaid managed care payor categories are not brocken down to

reflect HMO/PPO status.

The Hospital experienced a change in ownership--from Columbia HCA to Memorial Hermann Healthcare System--in October 1999. At that time the hospital changed its system for grouping financial classes to conform with Memorial Hermann's classification system. By necessity HCA the Healthcare Company has continued to submit the hospital's data to THCIC but is unable to accommodate any individual hospital mappings.

This complication is expected to continue through third quarter 2002 when the hospital expects to be off of the HCA System.
==========
THCIC ID: 537000 / Scott & White Memorial Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Data Content
To the best of our knowledge and ability with the configuration of our data systems, and the fact the data has gone through edits by other entities, the encounter data returned accurately represents the hospital inpatient and skilled nursing facility data from the UB92 billing claim form and data required by the state.

The information being certified does not indicate or address the quality of services that were provided and is not provided for that purpose. Instead, this information is extracted from a billing file that is solely used for administrative

purposes. Certain medical disciplines are responsible for the treatment of severely ill patients and physicians within those disciplines may experience a higher mortality rate due to the nature of their clinical practice. In addition, tertiary care facilities, such as ours often accept in transfer critically ill patients whose outcomes may adversely affect accepting institutions' performance profile. The data being submitted and certified is not meant to measure clinical quality.

Certification Process
It is possible that some cases discharged during this quarter were not included in the file submitted to the state due to the timing of submission required by the state. This may have occurred in instances when a case had not been billed before the tape was submitted, or when a correction of a billing error was made after the tape was submitted. Due to the volume of encounters for this certification period, time constraints and the resources needed for this process, the facility did not have an efficient method for verifying, auditing and correcting data at the encounter level.

Organization of Data
We are a teaching facility and the structure of our inpatient care is such that multiple physicians are involved in the patient's care in a serial fashion over the total duration of the patient's episode of care. Therefore, based solely on the billing file data, we cannot accurately assign a single physician as being largely responsible for the care of a patient when there may have been more than one attending physician involved in the care of the patient. For internal data analysis, the discharging physician has long been used as the responsible physician when assigning DRG's (Diagnosis Related Groups) or computing mortality statistics.
The attending physician reported in this data submission to THCIC might not be consistent with our assessment of the discharging physician.

Diagnosis/Procedure Code Summary
Being a teaching facility, we do assign more diagnoses and procedures than are captured on the UB92 billing claim form. The average number of diagnoses per encounter should read 6.6. This number is under-represented by THCIC methodology.

Standard/Non-Standard Source of Payment
This level of specificity is not required on the UB92 claim, therefore additional programming was done that may need additional attention to accurately capture the specified categories under Non-Standard Source of Payment.

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THCIC ID: 547000 / Fort Duncan Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

Data for 4th quarter 1999 is certified with the following comments:

1. Data indicates 5 deaths; actual was 21 deaths
2. Self Pay indicates 93; actual was 118 - these were included with the commercial
discharges.
3. Charity is not indicated; these are included with the self-pay.

==========

THCIC ID: 549000 / Baylor/Richardson Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

Diagnosis and Procedures
The UB92 claims data format which the state is requiring hospitals to submit, only accepts the first 9 diagnosis codes and the first 6 procedure codes. As a result, these records will not reflect every code from an individual patient record that was assigned. Thus the state's data file may not fully represent all diagnoses treated at the hospital, or all procedures performed by the hospital. Therefore true total volumes and severity of illness may not be accurately represented by the state's data file, making percentage calculations inaccurate.

Race/Ethnicity
When patients are admitted, the hospital does not routinely inquire as to their race and/or ethnicity. Thus analysis of these two data fields will not accurately describe the true population served by the hospital. The hospital does not discriminate based on race, color, ethnicity, gender or national origin.

Cost/ Revenue Codes
The state data files will include charge information. It is important to understand that charges do not equal payments received by the hospital. Payments are much less than charges, due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost for care that each patient receives.

Quality and Validity of the process
Processes are in place to verify the integrity and validity of the claims data. Steps are taken to ensure that the information sent to the state matches what is in the hospitals system. Occasionally, due to timing issues not all patient claims are submitted. If a case was not billed prior to data submission, that patient will not be included in the current submission, nor will it be included in any future data submissions. An example of why this would occur, is the patient is discharged on the last day of the calendar quarter, and not allowing adequate time to issue a bill or the case was extremely complex requiring extra time for coding.

Insurance - Source of Payment Data

Standard Source of Payment data reflects 78.84% missing/invalid, and Non-Standard
Source of Payment reflects 100% missing/invalid. This data is a result of the editing software utilized during 1999. The software utilized by the hospital was updated to meet THCIC specifications. However, the DFW

Hospital Council software had not been updated, therefore a discrepancy exists, and data does not accurately reflect Source of Payment information.

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THCIC ID: 574000 / Wagner General Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Wagner General Hospital had 4 discharges for 4th Qtr 1999. THCIC processed 5 discharges because of a duplicate claim submitted by WGH.

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THCIC ID: 586000 / Baylor Specialty Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Data Content
This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate; this was a unique, untried use of this data as far as hospitals are concerned.

Submission Timing
Baylor Specialty Hospital (BSH) estimates that our data volumes for the calendar year time period submitted may include 96% to 100% of all cases for that time period. The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in.

Diagnosis and Procedures
BSH is different from most hospitals submitting data to the state. We provide complex medical services to patients who have experienced a catastrophic illness and/or complex body system failure that requires coordinated, intensive treatment and care. Many of the patients have received emergency care and stabilizing treatment at another acute care hospital. They are admitted to BSH to continue their recovery and focus on improving their medical condition and/or functional ability in order to improve their quality of life to the fullest extent possible.

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture

of a patient's hospitalization, sometimes significantly.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Patient diagnoses and procedures for a particular hospital stay at BSH are assigned ICD-9-CM codes according to standard coding practices. Because of our unique patient population, however, comparisons against all other hospitals in the database would not be accurate. It is unclear whether coding practice across all long term acute care hospitals is consistent, so caution should be used when making comparisons and/or drawing conclusions from the data.

Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Medical recovery can be a long, arduous process depending on the severity of illness or injury. Due to the unique nature of medically complex patients, length of stay data cannot accurately be compared with data from hospitals that primarily treat an acute or emergent episode of illness or injury.

Race/Ethnicity
During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race data element is subjectively captured and the ethnicity data element is derived from the race designation. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used

by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Upon review of the certification data, it was found that 7% of the "White" encounters were incorrectly categorized as "Other" as well as 4% of the "Black" encounters.

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record might change over time.

Additionally, those payers identified contractually as both "HMO and PPO" are categorized as "Commercial PPO". Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

Certification Process
Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. During the current certification phase, Baylor did not have an efficient mechanism to edit and correct the data. In addition, due to the volume at BSH, it is not feasible to perform encounter level audits.

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THCIC ID: 597000 / Seton Edgar B Davis
QUARTER: 4
YEAR: 1999

Certified with comments

Seton Edgar B. Davis is acommunity hospital that serves the Caldwell County and surrounding rural areas asamedical/surgical facility. The transfer oftheseriously illand injured isreflectedinthelengths ofstay and mortallity rate.

Admission Source and Type:

Seton Edgar B. Davis experienced a data collection problem which will not affect the data previously submitted by the hospital

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THCIC ID: 600000 / CHRISTUS St John Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

St. John certified the data but could not account 19 patients due to processing the patients after the data was submitted.

During this time period St. John Hospital provided charity care for 37 patients with the total charges $ - 314,924.69 dollars. The system didn't identify these patients.

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THCIC ID: 601000 / Rio Grande Regional Hospital
QUARTER: 4th
YEAR: 1999

Certified with comments

Concerns with incorrect physician license numbers. Numbers have been corrected fro 2000 data but 1999 does have errors. Some physicians have expressed concern over data they feel is incorrect such as mortality rates. They are very concerned as to how the state is calculating this dataasn why the data defaults to them if they are only the admitting physician and not the attending physician.

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THCIC ID: 602000 / South Austin Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Data submitted by South Austin Hospital includes Skilled Nursing Facility as well as Acute patients, effectively increasing our lengths of stay.

The data is administrative/claims data, not clinical research data. There may be inherent limitations to using it to compare outcomes. Race/ethnicity classification is not done systematically with or between facilities. Caution should be used when analyzing the data within one facility and between facilities. The public data will only contain a subset of the diagnoses and procedure codes, thus limiting the ability to access all of the diagnoses and procedures relative to each patient.
The relationship between cost of care, charges and revenue that a facility receives is extremely complex. Charity patients are a subset of our self-pay category. Inferences to comparing costs of care from one hospital to the next may result in unreliable results.

The severity grouping assignment performed by the State using the APR-DRG grouper cannot be replicated by facilities unless they purchase the grouper. Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation of the data.

There is tremendous uncertainty about how robust physician linkages will be done across hospitals.

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THCIC ID: 603000 / Medical Center at Lancaster
QUARTER: 4
YEAR: 1999

Certified with Comments:

This is claims data, not clinical research data. There may be inherent limitations in using it to compare outcomes.

The public data only contains a subset of diagnosis and procedure codes.

The relationship between cost of care, charges and the revenue that a facility receives is extremely complex. Inferences to comparing charges from one hospital to the next may have unreliable results.

Race/ethnicity classification is not done systematically at each hospital.

Our hospital does not capture charity data at time of billing.

The designation of attending physician is usually assigned to the physician that discharges the patient. In some cases this does not reflect the physician that provided most of the patient care.

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THCIC ID: 608000 / Round Rock Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

Charity cases are a subset of the selfpay category.

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THCIC ID: 609001 / Memorial Hermann Fort Bend Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Medicare and Medicaid managed care payor categories are included with Medicare and Medicaid regular payor categories.

The Hospital experienced a change in ownership--from Columbia HCA to Memorial Hermann Healthcare System--in October 1999. At that time, the hospital changed its system for grouping financial classes to conform with Memorial Hermann's classification system. By necessity HCA the Healthcare Company has continued to submit the hospital's data to THCIC but is unable to accomodate any individual hospital mappings.

Medicare Managed care patients consisted of 23% of the total Medicare population and 5% of the entire hospital's population. Medicaid Managed care patients consisted of 52% of the total Medicaid population and 10% of the entire hospital's population.

This complication is expected to continue through third quarter 2002 when the hospital expects to be off of the HCA System.

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THCIC ID: 611000 / Regional Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

Regional Medical Center has a Psychiatric Unit in operation during this time period.

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THCIC ID: 616000 / HEALTHSOUTH Rehabilitation Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

4th Quarter1999 Patient Discharge Status should read:

Discharge to Home or Self Care	100
Discharge/Transfer to Gen. Hospital	30
Discharge/Transfer to SNF	2
Discharge to ICF	15
Discharge/Transfer to Home Health	25
Left AMA	2
Discharge/Transfer Home IV	1

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THCIC ID: 620000 / McAllen Medical Center
QUARTER: 4
YEAR: 1999

Certified with comments

Physician license numbers and names have been validated with the physician and the websites as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

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THCIC ID: 624000 / Denton Community Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

1. There is some difference in the total number of encounters for this quarter. THCIC indicates 1714 discharges. Our internal system counts 1737.
2. THCIC data shows 99 patients as "Black" and "182" as "Other". Unable to accurately ascertain Race if patient does not personally come through registration. Clerks are using "best observed guess" .
3. THCIC data shows 230 newborns. Our internal system shows 243.

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THCIC ID: 627000 / Harris Methodist Southwest
QUARTER: 4
YEAR: 1999

Certified with comments

This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

The State requires us to submit inpatient claims, by quarter/year, gathered from a form called a UB92, in a standard government format called HCFA 1450 EDI electronic claim format. The state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming but the public should not conclude that billing data sent to your payers is inaccurate; this was a unique, untried use of this data as far as the hospitals are concerned.

Several issues might affect the accuracy of any data gathered in this manner:

1. The State requires us to submit a "snapshot" of billed claims, extracted from our database approximately 20 days following the close of the quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in.

2. The data submitted matches the State's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the State allows us to include for each patient. In other words, the State's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 20% of HMSW patient population have more than nine diagnoses and/or six procedures assigned.

The State is requiring us to submit ICD9 data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses and the first six procedure codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the State's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

3. The length of stay data element contained in the State's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

4. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. HMSW's normal hospital registration process defaults to "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD9 diagnoses. Admission source does not give an accurate picture. The current summary of HMSW data shows 100% normal newborns which has been the case at all THR facilities.

5. During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race data element is subjectively captured and the ethnicity data element is derived from the race designation. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The State has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the State's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the Hospital.

6. The standard and non-standard sources of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. Several problems with Harris entity "mapping" have been identified. Blue Cross has been mapped incorrectly so that HMSW appears to have an unreasonably low number of Blue Cross patients. Workmen's compensation and Charity must be mapped differently. The current summary incorrectly states that HMSW had no Charity cases during this time frame.

7. The State requires that hospitals submit revenue information including charges.
It is important to note that charges are not equal to actual payments received by the
hospital or hospital cost for performing the service. Typically actual payments are
much less than charges due to managed care-negotiated discounts and denial of payment
by insurance companies.

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THCIC ID: 635000 / North Dallas Rehabilitation Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

DUE TO SOFTWARE PROBLEMS THE 4TH QTR 99 CERTIFICACION REPORTS DID NOT SHOW THE FINANCIAL INFORMATION ACCURATELY. IN OVER 70% OF THE ENCOUNTERS THE PATIENT CHARGES AND LENGTH OF STAY APPEARED DUPLICATED OR SUBSTANCIALLY OVERSTATED.

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THCIC ID: 639000 / Rehabilitation Hospital of South Texas
QUARTER: 4
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 4th Quarter 1999. Review of the certification reports and data by THCIC identified the following errors or missing values:
Procedure codes are missing

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THCIC ID: 642000 / Baylor Institute for Rehabilitation at Gaston
QUARTER: 4
YEAR: 1999

Certified with comments

Data Content
This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

The state requires us to submit inpatient claims, by quarter year, gathered from a form call a UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate; this was a unique, untried use of this data as far as hospitals are concerned.

Submission Timing
Baylor Institute for Rehabilitation (BIR) estimates that our data volumes for the calendar year time period submitted may include 89% to 100% of all cases for that time period. The state requires us to submit a snapshot

of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in. BIR has a 10-day billing cycle; therefore we will have a higher percentage of incomplete encounters than hospitals with a 30-day billing cycle.

Diagnosis and Procedures
BIR is different from most hospitals submitting data to the state. We provide comprehensive medical rehabilitation services to patients who have lost physical or mental functioning as a result of illness or injury. Many of these patients have already received emergency care and stabilizing treatment at an acute care hospital. They are admitted to BIR to continue their recovery and focus on improving their functional ability in order to improve their quality of life to the fullest extent possible.

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnosis codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Patient diagnoses and procedures for a particular hospital stay at BIR are assigned ICD-9-CM codes according to standard coding practices. Because of our unique patient population, however, comparisons against all other hospitals in the database would not be accurate. It is unclear whether coding practice across all comprehensive medical rehabilitation facilities is consistent, so caution should be used when making comparisons and/or drawing conclusions from the data.

Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Medical rehabilitation can be a long, arduous process depending on the severity of illness or injury. Due to the unique nature of rehabilitation services, length of stay data cannot accurately be compared with data from hospitals that primarily treat an acute or emergent episode of illness or injury.

Race/Ethnicity
During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race data element is subjectively captured and the ethnicity data element is derived from the race designation. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project, but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identification must be categorized into the appropriate standard and non-standard source of payment value. With this in mind, approximately 34.46% of encounters originally categorized across all values have a different value as of today. Upon review an additional data issue was uncovered. All managed care encounters were categorized as "Commercial PPO" instead of separating the encounters into "HMO" versus "PPO".

Additionally, those payers identified contractually as both "HMO and PPO" are categorized as "Commercial PPO". Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Cost/Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

Certification Process
Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. During the current certification phase, BIR did not have an efficient mechanism to edit and correct the data. In addition, due to the volume at BIR,

it is not feasible to perform encounter level audits.
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THCIC ID: 643000 / San Antonio Warm Springs Rehabilitation Hospital
 QUARTER: 4
    YEAR: 1999

Certified with comments

Error code 957 continutes to be a software issue.
==========
THCIC ID: 649000 / St Davids Rehabilitation Center
 QUARTER: 4
    YEAR: 1999

Certified with comments

1.) The data is administrative/claims data, not clinical research data.
 There may be inherent limitations to using it to compare outcomes.

2.) The public data will only contain a subset of the diagnoses and procedure codes, thus limiting the ability to access all of the diagnoses and procedures relative to each patient.

3.) The relationship between cost of care, charges and the revenue that a facility receives is extremely complex. Inferences to comparing costs of care from one hospital to the next may result in unreliable results.
==========
THCIC ID: 652000 / Harris Continued Care Hospital
 QUARTER: 4
    YEAR: 1999

Certified with comments

All "Admission Types" to this facility are Elective.
All "Admission Sources" to this facility are Transfers from Hospital.
==========
THCIC ID: 653000 / Zale Lipshy University Hospital
 QUARTER: 4
    YEAR: 1999

Certified with comments, corrections requested

1. Zale Lipshy University Hospital is an academic teaching hospital.
2. Zale Lipshy University Hospital is a private, adult referral hospital
 located on the campus of UT Southwestern Medical Center.
3. Zale Lipshy University Hospital does not provide for the following
 types of medical services: pediatrics and obstetrics.
4. Our charity cases are determined after final billing; therefore, they
 are not quantified in this report.
5. The file definition for self-pay does not adequately display billing
 for secondary and tertiary billing specifications.
6. Admission Source: physician and clinic are used interchangeably at
 our institution.
7. Admission Source: correctional facility code and court ordered admission
 code are used as one code.
8. The corrected data have been accepted by Commonwealth.
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THCIC ID: 664000 / Presbyterian Hospital of Plano
QUARTER: 4
YEAR: 1999

Certified with Comments:

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Patient Population Characteristics:
Low volume in the overall cardiac surgery program is due to a start up program that began in February, 1999.

Diagnosis and Procedures

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-9-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An "apples to apples" comparison cannot be made which makes it difficult to obtain an accurate comparison of hospital or physician performance.

The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization.

For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission, or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
Approximately 5% of PRESBYTERIAN HOSPITAL OF PLANO's patient population have more than nine diagnoses assigned.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned.
This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format.
It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification
database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Admit Source data for Normal Newborn
When the Admit type is equal to "newborn", the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural
birth, or information not available. The best way to focus on severity of illness
regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to "normal delivery" as the admission source. Therefore, admission source does not always give an accurate picture.

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data.
PRESBYTERIAN HOSPITAL OF PLANO recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity
During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race and ethnicity data elements are subjectively captured. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identification must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both "HMO, and PPO" are categorized as "Commercial PPO". Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

Bill Types
Due to data export considerations, all inpatient's are designated as bill type 111.
This includes all skilled nursing admissions should be designated as bill type 211
and 221. The result is an overall LOS that is slightly increased.

Certification Process
Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and as thorough as all parties would like to see in the future. Within the constraints of the current THCIC process the data is certified to the best of our knowledge as accurate.

Physician Comments:
The neonatal ICU began treating infants at 32-34 weeks gestation in August of 1999, which may increase the acuity and complication rate for newborns.
Erik W. Gunderson, MD
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THCIC ID: 677000 / North Central Baptist Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Comments:
This is administrative data that has been collected on a national standard form called a UB-92, for the purpose of billing third party organizations for reimbursement.
This billing data was not collected for clinical purposes from which one could easily
make judgements about patient care. Acknowledging the constraints and limitations of
the THCIC process, to the best of our knowledge the THCIC data are reasonable representations of the administrative data except for two items that merit specific comment.

Standard/Non-Standard Sources of Payment
This data is not contained within the national standard UB-92 record used for billing.
Therefore, additional programming was required to capture and provide the specified
categories of payment. The effectiveness of this programming will be monitored and

refined on a go-forward basis to achieve an appropriate degree of accuracy in the data.

Age Classification of Patients
The data reflect several occurrences of highly unusual reported ages of patients in
the Normal Newborn, Vaginal Delivery and Neonate categories and we cannot attest to
the accuracy of this suspect data. We are researching these variances in an effort
to determine the cause for the aberrations in reported ages.
==========

THCIC ID: 679000 / Burleson St Joseph Health Center of Caldwell
QUARTER: 4
YEAR: 1999

Certified with comments

Data Source - The data included in this file is administrative, not clinical research data. Administrative data may not accurately represent the clinical details of a patient visit. This data should be cautiously used to evaluate health care quality and compare outcomes.

Charity Care - Data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for Burleson St. Joseph Health Center charity care, based on established rates during the calendar year of 1999 was $248,627.

Patient Mix - All statistics for Burleson St. Joseph Health Center include patients from our Skilled Nursing, and Acute Care populations. Our Skilled Nursing unit is a long-term care unit. Because of this Mortality and Length of Stay may be skewed. This will prohibit any meaningful comparisons between Burleson St. Joseph Health Center and any "acute care only" facilities.

Physicians - Mortality's reported may be related to physicians other than the attending
Physician. The attending physician is charged with the procedures requested or performed by the consulting or specialist physicians.

Diagnosis and Procedures - Data submitted to the state may be incomplete for some patients due to the limitation on the number of diagnosis and procedures codes allowed. The data is limited to nine diagnoses codes and six procedure codes per patient visit.

Cost and Charges - The state requires that we submit revenue information including charges. It is important to note that charges do not reflect actual reimbursement received, nor do they reflect the actual cost of providing the services. Typically actual payments received are much less than the charges due to managed care-negotiated discounts, denial of payment by insurance companies, contractual allowances, as well as charity and un-collectable accounts. The relationship between cost of care, charges, and the revenue a facility receives is extremely complex. Comparing costs of care from one hospital to the next may result in unreliable results.

Severity Adjustment - THCIC is using the 3M APR-DRG grouper to assign the APR-DRG (All-Patient Refined Diagnoses Related Grouping) severity and risk of mortality scores. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status. This grouper can only use the limited number of procedure and diagnosis codes available in the data file (nine diagnosis and six procedure codes). If all the patient's diagnosis codes were available the APR-DRG assignment may possibly differ from the APR-DRG assigned by THCIC. The severity grouping assignment performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper.

Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation
of the data.

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THCIC ID: 681400 / Kell West Regional Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Inaccracies due to version of vendors software. We are currently working with the vendor on loading the upgrades.

==========

THCIC ID: 684000 / HEALTHSOUTH Rehabilitation Hospital of Texarkana
QUARTER: 4
YEAR: 1999

Certified with comments

Due to a system error, all patient discharges for the fourth quarter of 1999 were eroneously coded as 01 (patient discharged to home). The actual patient discharge status break-out is as follows:

Discharge location code:	Number of Patients:
01 Home, NO Home Health	101
02 Board & Care	1
03 Transitional Living	3
05 Skilled Nursing	38
07 Acute Unit @ other med facility	16
08 Chronic Hospital	1
09 Rehabilitation Facility	3
10 AMA	1
11 Died	1
12 Alternate Level of Care (SNF Unit)	1
50 Home with Home Health	63

Total patients discharged = 229

==========

THCIC ID: 686000 / Covenant Childrens Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Data does not accurately reflect the number of charity cases for the time period. This is due to internal processing for determination of the source of payment.
4% of total discharges were charity for 4 Quarter 1999.

==========

THCIC ID: 690600 / LifeCare Hospital of Fort Worth
QUARTER: 4
YEAR: 1999

Certified with comments

The following are corrections. Patient race is: Black=9, White=73, Other=2 and Missing or Invalid=5. Patient discharge status is: D/C to Home=22, D/C / Transfer to Gen Hosp.=4, D/C to ICF=31, D/C / Transfer to other insitution=2, D/C / Transfer to Home Health=19, Left AMA-1. Standard Source of Payment is Medicare=83 and Commercial=6.

==========

THCIC ID: 691000 / Memorial Specialty Hospital
QUARTER: 4th
YEAR: 1999

Certified with comments

We received no response from physicians regarding data. We understand their may be discrepencies in some data but are making every effort to correct this on future submissions.

==========

THCIC ID: 692000 / HEALTHSOUTH Rehabilitation Hospital of Tyler
QUARTER: 4
YEAR: 1999

Certified with comments

Results do not accurately reflect discharge disposition status.

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THCIC ID: 694100 / Vista Medical Center Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

Four (4) DRG 497's should be changed to DRG 498. The secondary diagnosis that drives the DRG is incidental to the procedure and should be deleted.

Four (4) DRG 500's are listed under an incorrect physician.

One (1) DRG 243 is listed under an incorrect physician.

==========

THCIC ID: 695000 / HEALTHSOUTH Rehabilitation Hospital North Houston
QUARTER: 4
YEAR: 1999

Certified with comments

4th Quarter 1999 Patient Discharge Status should read as follows:

Discharge to Home or Self Care	115
Discharge/Transfer to Gen. Hospital	30
Discharge/Transfer to SNF	7
Discharge to ICF	15
Discharge/Transfer to Other Institution	1
Discharge/Transfer to Home Health	29
Left AMA	2
Discharge/Transfer Home IV	1
Expired	1
Missing/Invalid	1

==========

THCIC ID: 698000 / The Specialty Hospital of Houston

QUARTER: 4
YEAR: 1999

Certified with comments

1. Due to technical issues with Information Systems the discharge data for the quarter is not accurate. The Technical issues are related to vendor and patient account numbers. Please note that these issues are said to be resolved as of this date.
2. The admissions type for all admissions are coded as "urgent". This information is incorrect and should be "elective" admissions.
3. The admission source for all the patients is coded as "physician" This information is incorrect. Not all of the admissions are from physicians, other sources include transfers from hospitals and Skilled Nursing facilities.
4. Physicians and other health care professionals were not provided an opportunity to review the data for accuracy secondary to time constraints.
5. Please note that this data is half of the total data for the Specialty Hospital of Houston. There are two campuses to one hospital (698000 & 698001) . Due to the inability to merge the data to reflect one hospital; the data is submitted by campus. So, please consider both campuses when reviewing data for Specialty Hospital of Houston.

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THCIC ID: 698001 / Specialty Hospital Houston - Clear Lake Campus
QUARTER: 4
YEAR: 1999

Certified with comments

1. Due to technical issues with Information Systems the discharge data for the quarter is not accurate. The Technical issues are related to vendor and patient account numbers. Please note that these issues are said to be resolved as of this date.
2. The admissions type for all admissions are coded as "urgent". This information is incorrect and should be "elective" admissions.
3. The admission source for all the patients is coded as "physician" This information is incorrect. Not all of the admissions are from physicians, other sources include transfers from hospitals and Skilled Nursing facilities.
4. Physicians and other health care professionals were not provided an opportunity to review the data for accuracy secondary to time constraints.
5. Please note that this data is half of the total data for the Specialty Hospital of Houston. There are two campuses to one hospital (698000 & 698001) . Due to the inability to merge the data to reflect one hospital; the data is submitted by campus. So, please consider both campuses when reviewing data for Specialty Hospital of Houston.

==========

THCIC ID: 700000 / The Specialty Hospital of Austin
QUARTER: 4
YEAR: 1999

Certified with comments

Due to technical issues and various other time constraints, physicians and other individuals were not given adequate time to view the data. The data contained herein is not an exact representation of the actual discharge data for the specified quarter.

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THCIC ID: 700001 / The Specialty Hospital of Austin at North Austin Medical Center
 QUARTER: 4
    YEAR: 1999

Certified with comments

Due to technical issues and various other time constraints, physicians and other individuals were not given adequate time to view the data. The data contained herein is not an exact representation of the actual discharge data for the specified quarter.

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THCIC ID: 700002 / The Specialty Hospital of Austin at St Davids Medical Center
 QUARTER: 4
    YEAR: 1999

Certified with comments

Due to technical issues and various other time constraints, physicians and other individuals were not given adequate time to view the data. The data contained herein is not an exact representation of the actual discharge data.

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THCIC ID: 703002 / The Corpus Christi Medical Center - Doctors Regional
 QUARTER: 4
    YEAR: 1999

Certified with comments

The summary numbers under the caption "Standard Source of Payment" and "Non-standard Source of Payment" do not accurately reflect the payor sources identified in the Corpus Christi Medical Center's billing records.

The summary numbers under the caption "Severity Index" are not calculated using the same system used by the Corpus Christi Medical Center, therefore, the Corpus Christi Medical Center is unable to verify the accuracy of these numbers.

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THCIC ID: 705000 / Texoma Medical Center Restorative Care Hospital
 QUARTER: 4
    YEAR: 1999

Certified with comments

Data Source. The source of this data, the electronic 1450, is administrative in nature, and was collected for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality.
- The 1450 data file limits the diagnosis codes to nine (principal plus eight secondary diagnosis codes); the admission diagnosis and an E-code field.
- The procedure codes are limited to six (principal plus five secondary).
- The fewer the codes the less information is available to evaluate the patient's outcomes and service utilization.
- The Hospital can only list 4 physicians that were involved with any

one patient. Other physicians who were involved in those cases will not be identified.

Payer Codes. The payer codes utilized in the THCIC data base were defined by the state. They are not utilizing the standard payer information from the claim.

Revenue Codes and Charges. Charges associated with the 1450 data do not represent actual payments or costs for services.

Severity Adjustment. THCIC is using the 3M APR-DRG system to assign the All-Patient Refined (APR) DRG, severity and risk of mortality scores. The scores represent a categorization of patient severity and mortality risk. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status.
- The program can only use the codes available in the 1450 data file, e.g., nine diagnosis and six procedure codes. If all the patient's diagnosis codes were available the assignment may be different than when limited to those available in the 1450 data.

Timing of Data Collection. Hospitals must submit data to THCIC no later than 60 days after the close of the quarter.
- Not all claims may have been billed at this time.
- Internal data may be updated later and appear different than the data on the claim. Unless the payment is impacted, the hospitals does not rebill when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

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THCIC ID: 706000 / Vencor Hospital Houston Northwest
QUARTER: 4
YEAR: 1999

Certified with comments

Vencor Hospital Houston Northwest is a long term acute care hospital.

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THCIC ID: 707000 / Quest Hospital
QUARTER: 4
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 4th Quarter 1999. Review of the certification reports and data by THCIC identified the following errors or missing values:
Procedure codes are missing
Some age groups are not valid
Some state codes and zip codes are missing

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THCIC ID: 708000 / Dubuis Hospital for Continuing Care - Beaumont
QUARTER: 4
YEAR: 1999

Certified with comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation

of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects. Therefore relevant comparisons should be made with only other Long Term Acute Hospitals.
Only acutely ill patients requiring an average length of stay of approximately 25 days are admitted to Dubuis Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital. In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems. Subsequently they require a longer hospital stay than the younger population

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THCIC ID: 710000 / Our Childrens House at Baylor
QUARTER: 4
YEAR: 1999

Certified with comments

Data Content
This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate; this was a unique, untried use of this data as far as hospitals are concerned.

Submission Timing
Our Children's House at Baylor (OCH) estimates that our data volumes for the calendar year time period submitted may include 96% to 100% of all cases for that time period. The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in.

Diagnosis and Procedures
OCH is different from most hospitals submitting data to the state. We provide complex medical services to patients who have experienced a catastrophic illness, congenital anomalies and/or complex body system failure that requires coordinated, intensive treatment and care. Many of the patients have received emergency care and stabilizing treatment at another acute care hospital or another children's acute care hospital. They are admitted to OCH to continue their recovery and focus on improving their medical condition.

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Patient diagnoses and procedures for a particular hospital stay at OCH are assigned ICD-9-CM codes according to standard coding practices. Because of our unique patient population, however, comparisons against all other hospitals in the database would not be accurate. It is unclear whether coding practice across all Children's hospitals is consistent, so caution should be used when making comparisons and/or drawing conclusions from the data.

Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Medical recovery can be a long, arduous process depending on the severity of illness or injury. Due to the unique nature of medically complex patients, length of stay data cannot accurately be compared with data from hospitals that primarily treat an acute or emergent episode of illness or injury.

Race/Ethnicity
During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race data element is subjectively captured and the ethnicity data element is derived from the race designation. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific

codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record might change over time.

Additionally, those payers identified contractually as both "HMO and PPO" are categorized as "Commercial PPO". Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

Certification Process
Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. During the current certification phase, Baylor did not have an efficient mechanism to edit and correct the data. In addition, due to the volume at OCH, it is not feasible to perform encounter level audits.

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THCIC ID: 713000 / CHRISTUS St Michael Rehabilitation Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

These are true to the best of my knowledge.
Chris Karam
Vice President/C.O.O.

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THCIC ID: 713400 / Triumph Hospital North Houston
QUARTER: 4
YEAR: 1999

Certified with comments

During the fourth quarter 1999, the facility underwent a JCAHO / Medicare deemed status survey. As a result of the survey, the facility received its Medicare certification.. Two patients were in-house at the time of the survey. For the period from admission to the facility Medicare certification
date, these patients were billed as self pay patients. For the period from the facility's Medicare certification thru actual patient discharge, these patients were billed as Medicare patients.

The facility was unable to correct the error codes created by this cross-over.
As such, encounters for these two patients were not built.

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THCIC ID: 717000 / LifeCare Specialty Hospital of Dallas
QUARTER: 4
YEAR: 1999

Certified with comments

The following are corrections: Patient race 10% Asian, 45%, Black, 35% White, and 10% Hispanic. Patient ethnicity for 1999 was 10% Hispanic.

==========

THCIC ID: 727000 / The Oaks Treatment Center
QUARTER: 4
YEAR: 1999

Certified with comments

The Oaks Treatment Center provides long-term residential treatment to adolescents with severe emotional disturbances. No hospital programs are in operation. This should be taken into consideration when comparing this facility's discharge data with other hospitals who may be providing acute care services.

Please note the THCIC software is not equipped to store length of stay data over 999 days. For stays exceeding 999 days, the THCIC system rounds down the actual LOS to a maximum of 999 days. The system, however, does report the actual charges for the entire stay. This should be taken into consideration when interpreting ALOS and charge data for this facility as some patient stays exceed 999 days.

==========

THCIC ID: 735000 / TIRR LifeBridge
QUARTER: 4
YEAR: 1999

Certified with comments

TIRR LifeBridge is a fully accredited teaching specialty hospital that provides transitional medical transitional and general rehabilitation. The philosophy of LifeBridge is to assist patients in attaining the highest level of function possible within the resources available to them. LifeBridge works closely with the patient and his/her family and the External Case Manager to provide care effectively at an appropriate level. Patient care is offered in general clinical
services including:

* Stroke
* Cancer Recovery
* Wound and Skin Care Management
* Post Surgical Care
* General Rehabilitation
* Neuromuscular Complications of Diseases or Injuries
* Ventilator and Other Respiratory Care
* Brain Injury Recovery, Including Coma
* Complex Diabetes
* Orthopedics

Types of Services
General rehabilitation services are provided for patients who have limited tolerance
for participation or benefit from a comprehensive acute rehabilitation program. Medical transitional services are designed for patients who need specialized care
for medical issues that do not require an acute care hospital setting. The types
of services include:
* Pulmonary/Ventilator
* Strength/Endurance Exercises
* Complex Wound Care
* Speech/Language Intervention
* Bowel/Bladder Training
* Alternative Communication Techniques
* Positioning
* ADL Training
* Patient/Family/Attendant Training
* Mobility Training
* Gait Training

THCIC data show TIRR LifeBridge as a "SNF Facility". TIRR LifeBridge operated a SNF unit until December 1998, when the unit was converted back to long term acute care.

==========

THCIC ID: 736000 / DePaul Center - Div of Providence Health Center
QUARTER: 4
YEAR: 1999

Certified with comments

Due to a data mapping error, 9 records from the DePaul Center (THCIC #763000) were inadvertently submitted under Providence Health Center's THCIC Number (THCIC #040000). The accounts had the following HCFA DRGs:

HCFA DRG NO - Quantity
HCFA DRG 426 - 1
HCFA DRG 427 - 1
HCFA DRG 430 - 5
HCFA DRG 431 - 2

==========

THCIC ID: 737000 / Southwest Mental Health Center
QUARTER: 4
YEAR: 1999

Certified without comments

Due to a bill type error, 326 patients did not have encounters created.
We have taken steps to correct this problem.

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THCIC ID: 753000 / San Marcos Treatment Center
QUARTER: 4
YEAR: 1999

Certified with comments

San Marcos Treatment Center provides long-term residential treatment to

adolescents with severe emotional disturbances. No hospital programs are in operation. This should be taken into consideration when comparing this facility's discharge data with other hospitals who are providing acute care services.

Please note the THCIC software is not equipped to store length of stays over 999 days. For stays exceeding 999 days, the THCIC system rounds down the actual LOS to a maximum of 999 days. The system, however, does not round down the actual charges, but reports the actual charge for the entire LOS. This should be taken into consideration when interpreting average LOS and charge data for this facility as some patient stays exceed 999 days.

==========

THCIC ID: 754000 / Glen Oaks Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

All references to Jane Harmon, APN, as the attending physician are incorrect.

==========

THCIC ID: 763000 / Plaza Specialty Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

DATA SUBMISSION

The data included in the fourth quarter 1999 submission to the State is considered administrative data collected by Plaza Specialty Hospital for billing purposes and not used to make judgements about patient care. On a quarterly basis we submit only inpatient UB92 data to the State. The UB 92 is a standard billing form that all hospitals use to submit claims to payors. The information is submitted in a standard government format called HCFA 1450 EDI electronic claim format. The data must be submitted by the 20th day following the close of the quarter. Any accounts in the quarter not billed by the deadline will not be reflected in this data. In addition, it is important to note that the UB92 claim form only allows nine diagnoses and six procedure codes to be submitted. In addition only three physicians can be identified; attending physician, and two other physicians. Anyone evaluating this data should understand that our diagnoses/procedure data collection system allows us to enter twelve diagnoses codes, ten procedure codes and identify up to ten physicians. The additional diagnoses and procedures may have an impact on the severity level and APR/DRG assigned to the admission. Therefore the physician data, severity level and

APR/DRG assignments reported for some of these admissions may not be accurate.

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THCIC ID: 765000 / Millwood Hospital
QUARTER: 4
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 4th Quarter 1999. Review of the certification reports and data by THCIC identified the following errors or missing values:
Procedure codes are missing

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THCIC ID: 771000 / St Davids Pavilion
QUARTER: 4
YEAR: 1999

Certified with comments

1.) The data is administrative/claims data, not clinical research data. There may be inherent limitations to using it to compare outcomes.

2.) The public data will only contain a subset of the diagnoses and procedure codes, thus limiting the ability to access all of the diagnoses and procedures relative to each patient.

3.) The relationship between cost of care, charges and the revenue that a facility receives is extremely complex. Inferences to comparing costs from one hospital to the next may result in unreliable results.

==========

THCIC ID: 778000 / Harris Methodist Springwood
QUARTER: 4
YEAR: 1999

Certified with comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Diagnosis and Procedures

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An "apples to apples" comparison cannot be made
which makes it difficult to obtain an accurate comparison of hospital or physician performance.

The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission, or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 0.% of Harris Methodist Springwood's patient population have more than nine diagnoses and/ or
six procedures assigned.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450

format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Admit Source data for Normal Newborn
When the Admit type is equal to "newborn", the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to "normal delivery" as the admission source. Therefore, admission source does not always give an accurate picture.

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. THR recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity
During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race and ethnicity data elements are subjectively captured. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identification must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information,
because those payers identified contractually as both "HMO, and PPO" are categorized as "Commercial PPO". Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Currently, Harris Methodist Springwood has classified Workmen's Compensation to be included in "Commercial". This will be modified in the future. For 4th quarter 1999 there were no Wormen's Compensation inpatients.

Cost/ Revenue Codes

The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

Certification Process
Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and as thorough as all parties would like to see in the future. Within the constraints of the current THCIC process the data is certified to the best of our knowledge as accurate.

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THCIC ID: 779000 / The Cedars Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

The source of payment field, patient race field, and patient ethnicity field are not 10090 accurate due to compatability problems in the software, These problems are not correctable at this time.

==========

THCIC ID: 780000 / Harris Continued Care Hospital H.E.B.
QUARTER: 4
YEAR: 1999

Certified with comments

All "Admission Types" to this facility are Elective.
All "Admission Sources" to this facility are Transfers from Hospital.

==========

THCIC ID: 788000 / CHRISTUS St Michael Health System
QUARTER: 4
YEAR: 1999

Certified with comments

These are true to the best of my knowledge.
Chris Karam
Vice President/C.O.O.

==========

THCIC ID: 794000 / HEALTHSOUTH Surgical Hospital of Austin
QUARTER: 4
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 4th Quarter 1999. Review of the certification reports and data by THCIC identified the following errors or missing values:
Admission source, admission type, patient race and ethnicity, and length of stay may not be valid
Diagnosis codes not grouped because they have leading blanks
Procedure codes have leading blanks

==========
THCIC ID: 796000 / IHS Hospital of Amarillo
 QUARTER: 4
    YEAR: 1999

Certified with comments

Due to computer issues, the Admission Type data is inaccurate. The majority of admissions are urgent admissions. Computer changes have been made and urgent type will be reflected beginning in the 3rd Quarter 2000 data.
==========
THCIC ID: 797000 / North Austin Medical Center
 QUARTER: 4
    YEAR: 1999

Certified with comments

The data is administrative data that was collected for billing purposes and was not designed to allow judgements about patient care.

The public data set includes only a subset of diagnoses and procedure codes and will not accurately represent the sickest or most complicated patients.

The relationship between cost of care, charges, and revenue is complex. Inferences drawn from comparing different facilities' charges may be unreliable.

Charity care is not accurately reflected in the source of payment data. Patients who have no insurance are initially identified as "Self-Pay," but frequently become "Charity" after it is determined that they are unable to pay.

The severity grouping assignment performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper. Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation of the data.

Race and ethnicity classification is not done systematically within or between facilities. Caution should be used when analyzing this data within one facility and between facilities.

The data does not accurately reflect the number of PPO patients at North Austin Medical Center because of a computer mapping problem. PPO patients are currently included in the HMO classification.
==========
THCIC ID: 798000 / Summit Hospital of Central Texas
 QUARTER: 4
    YEAR: 1999

Certified with comments

Due to technical issues and various other time constraints, physicians and other individuals were not given adequate time to view the data. The data contained herein is not an exact representation of the actual discharge data.

==========

THCIC ID: 801000 / Vencor Hospital Bay Area Houston
QUARTER: 4
YEAR: 1999

Certified with comments

Vencor Hospital Bay Area - Houston is a Long Term Acute Care Hospital

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THCIC ID: 802000 / McAllen Heart Hospital
QUARTER: 4
YEAR: 1999

Certified with comments

RE: Comment to data submitted for quarter ending December 1999

Under Admission Source, MHH was credited two (2) encounters under Newborn Admission. For clarification, MHH does not admit newborns or do deliveries. The two (2) encounters that have been credited has to do with a patient that was 3 weeks post delivery that was admitted to MHH with an acute cholecystitis requiring surgery.

According to the Coding Clinic, Fourth Quarter 1995, advised to assign code 646.84 for cholecystitis that started during the pregnancy and to use code 674.84 if the cholecystitis is a true postpartum condition for a five week postpartum patient who is admitted with acute cholecystitis or cholelithiasis anytime during the five weeks postpartum.

In the two encounters mentioned above , the patient was three weeks postpartum with a true postpartum condition of acute cholecystitis which required surgery. She had a 3 day LOS with the first encounter and came back the day after discharge from the first encounter for outpatient testing (GI procedures).

Thus, the primary code of 674.84 was used for both encounters with the secondary diagnosis code of 576.60. Thus, the reason for the coding used for the two encounters, was not due to deliveries but to complications secondary to delivery.

==========

THCIC ID: 804000 / Sunrise Canyon
QUARTER: 4
YEAR: 1999

Certified with comments

A mapping issue caused admission source data and admission type data to be unreliable or incorrect. All admission type data should be recorded as urgent. All other data were not affected.

==========

THCIC ID: 806001 / Cedar Crest Hospital
 QUARTER: 4
    YEAR: 1999

Certified with comments

We are aware that all of our Non-Standard Sources of Payment are listed as "Missing/Invalid". We are currently trying to determine if this is a problem and why it continues to occur. We are submitting seventy-nine claims. One hundred thirteen claims should have been submitted, however, thirty-four claims have been omitted by accident due to a mapping problem. We are investigating how this occurred to ensure this never happens again.

==========

THCIC ID: 807000 / Dubuis Hospital for Continuing Care Houston
 QUARTER: 4
    YEAR: 1999

Certified with comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects. Therefore relevant comparisons should be made with only other Long Term Acute Hospitals.
Only acutely ill patients requiring an average length of stay of approximately 25 days are admitted to Dubuis Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital. In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems. Subsequently they require a longer hospital stay than the younger population.

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THCIC ID: 808000 / El Paso Psychiatric Center
 QUARTER: 4
    YEAR: 1999

Certified with comments

Percentage of total discharges, you indicate that $8843.19 average charge, 8.1 average LOS; however, no procedure code and description were showing. We did not
receive any data correction information and were not able to correct this information.

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THCIC ID: 810000 / Harris Continued Care Hospital
 QUARTER: 4
    YEAR: 1999

Certified with comments

All "Admission Types" to this facility are Elective.
All "Admission Sources" to this facility are Transfers from Hospital.

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THCIC ID: 814000 / Las Colinas Medical Center

1.   Newborn Admissions:
Las Colinas Medical Center had zero extramural births, NOT 5.

2. Patient Race:
A. Asian or Pacific Islander
Las Colinas Medical Center had 65, NOT 170.
B. Black
Las Colinas Medical Center had 102, NOT zero.
C. White
Las Colinas Medical Center had 493, NOT 499.
D. Other
Las Colinas Medical Center had 229, NOT 231.
==========
THCIC ID: 819000 / SCCI Hospital San Angelo
 QUARTER: 4
    YEAR: 1999

Certified with comments

There were 11 patients whose information was not certified for the fourth quarter of 1999.
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THCIC ID: 822000 / The Dubuis Hospital for Continuing Care Texarkana
 QUARTER: 4
    YEAR: 1999

Certified with comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects. Therefore relevant comparisons should be made with only other Long Term Acute Hospitals.
Only acutely ill patients requiring an average length of stay of approximately 25 days are admitted to Dubuis Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital. In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems. Subsequently they require a longer hospital stay than the younger population
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THCIC ID: 823000 / Methodist Health Center Sugar Land
 QUARTER: 4
    YEAR: 1999

Certified with comments

Certified with five files missing for quarter 4-99.
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THCIC ID: 827000 / Rio Grande Rehabilitation Hospital
 QUARTER: 4th
    YEAR: 1999

Certified with comments

Concerns with incorrect physician license numbers. Numbers have been corrected for 2000 data but 1999 does have errors. Some physicians have expressed concern over data that they feel is incorrect such as mortality rates. They are very concerned as to how the state is calculating this data and wshy the data defaults to them if they are only the admitting physician and not the attending physician.

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THCIC ID: 831000 / Victoria Warm Springs Rehabilitation Hospital
 QUARTER: 4
    YEAR: 1999

Certified with comments

Warning Code 957 is a software issue.